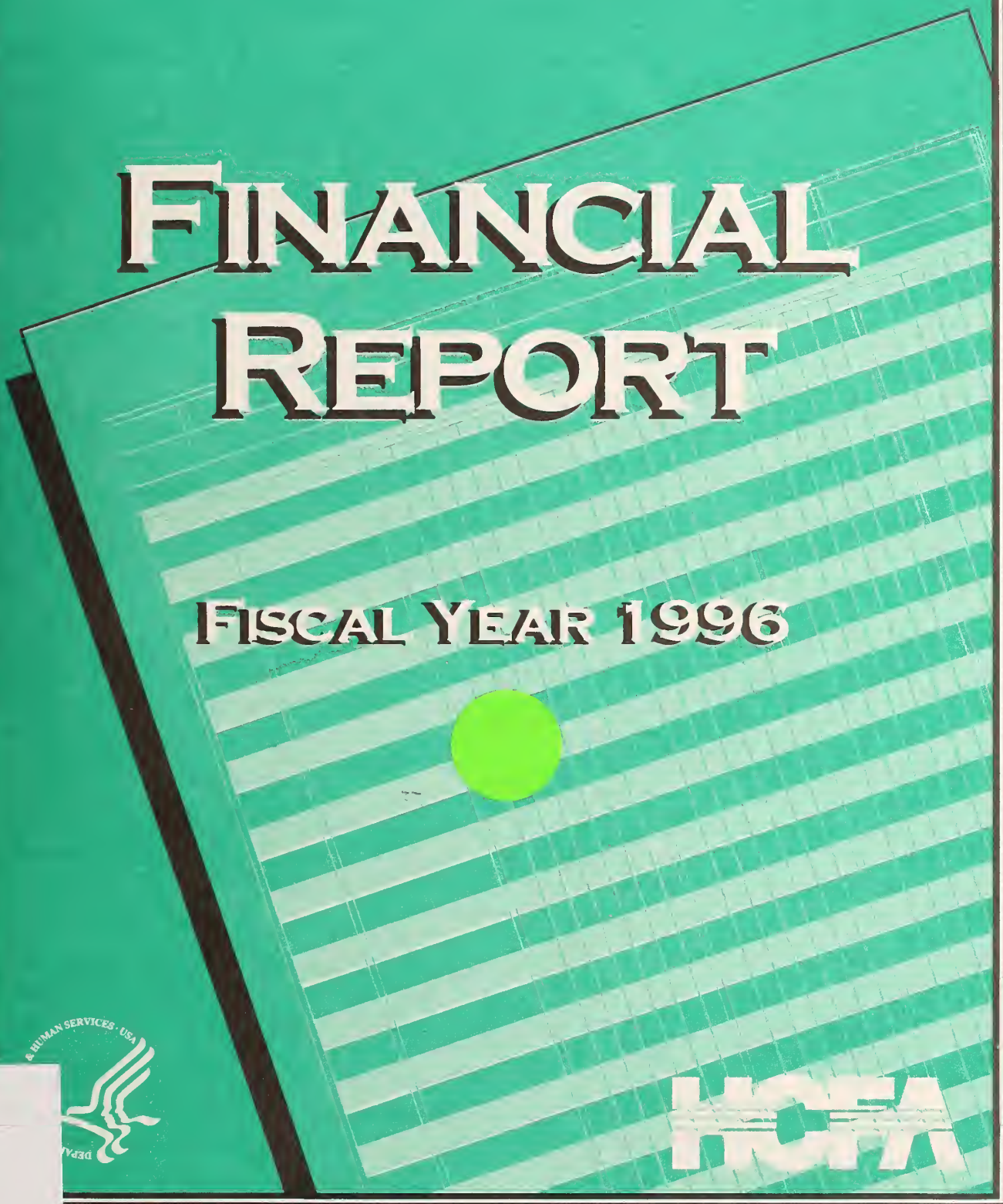
U.S. Department of Health and Human Services

Health Care Financing Administration

Financial Report

Fiscal Year 1996



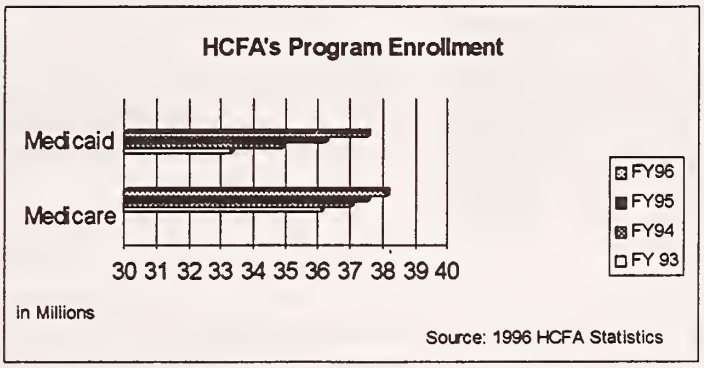
The Chief Financial Officers (CFO) Act of 1990 (P.L. 101-567) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompaning report.

The form and content of this Financial Report follow guidelines provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects HCFA's strong support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

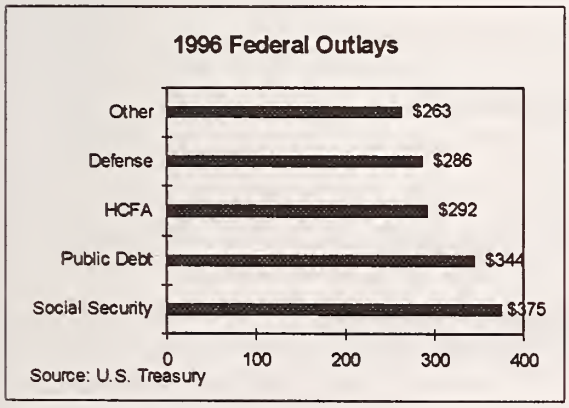
U.S. Department of Health and Human Services
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244

HCFA AT A GLANCE

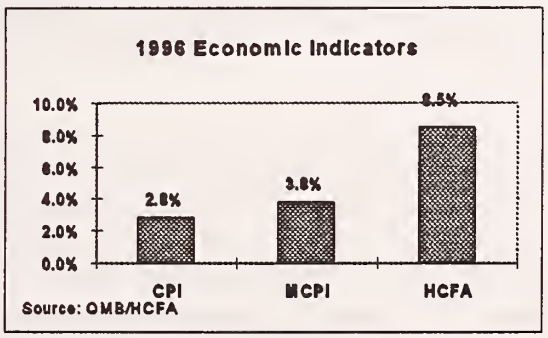
➤ HCFA celebrated the 30th Anniversary of the Medicare and Medicaid programs in 1996. Over the past 30 years, Medicare enrollment increased from 19.5 million beneficiaries in 1967 to 38.1 million beneficiaries today. Medicaid enrollment increased from 10 million beneficiaries in 1967 to 37.5 million beneficiaries. We cover one in four Americans.



➤HCFA has 3,980 Federal employees; 2620 are headquartered in Baltimore and Washington, and 1360 work in 10 cities around the country. HCFA is responsible for safeguarding the fiscal integrity of Medicare and Medicaid, assuring the safety and quality of medical facilities, providers, and suppliers, providing health insurance protections to workers changing jobs, and maintaining the largest collection of health care data in the United States. HCFA and its contractors pay about 807 million Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries.



➤ HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays represented 33.2 cents of every dollar spent on health care in the United States--47 cents of every dollar received by U.S. hospitals and 25.6 cents of every dollar received by other health care providers. HCFA and the programs it administers outlayed $292 billion in fiscal year (FY) 1996, 18.7 percent of the total Federal budget.



➤ Outlays for Medicare and Medicaid increased 8.5 percent from FY 1995 to FY 1996, more than 3 times faster than the general cost of living as measured by the Consumer Price Index (2.8%), and more than twice as fast as the CPI for medical goods and services (3.8%).

OUR MISSION, VISION, AND GOALS

MISSION

We assure health care security for beneficiaries. Health care security means access to affordable and quality health care services, protection of the rights and dignity of beneficiaries, and provision of clear and useful information to beneficiaries and providers to assist them in making health care decisions.

VISION

We guarantee equal access to the best health care. This vision reflects our commitment that all individuals will be given an unconditional assurance of having the same opportunity to have their health care needs met, regardless of location, income, or other circumstances, and the quality of health care they receive is the best that can be provided.

GOALS

- Build a high-quality, customer-focused team.
- Ensure programs and services respond to the health care needs of beneficiaries.
- Promote improved health status of beneficiaries.
- Be a leader in health care information resources management.
- Promote fiscal integrity of HCFA programs.
- Create excellence in the design and administration of our programs.
- Provide leadership in the continuing evolution of the health care system.

Message from the Administrator

I am pleased to provide the Health Care Financing Administration's (HCFA's) annual report for fiscal year 1996, the 30th Anniversary of the Medicare and Medicaid programs. Over the past 30 years, Medicare enrollment has increased 95 percent, from 19.5 million beneficiaries in 1967 to 38.1 million today. Over the same period, Medicaid enrollment has increased from about 10 million beneficiaries in 1967 to 37.5 million, a 275 percent increase.

HCFA is the largest health care purchaser in the world. Like other major purchasers, we are continually seeking strategies that will help us ensure high quality health care at a reasonable price. But we can neither formulate nor implement these strategies by ourselves. We must ensure that beneficiaries are able to make choices that meet their health care needs. We must also combine to work with other purchasers, Federal and State agencies, our contractors, and a range of providers to solicit their expertise, listen to their concerns, and develop better ways of doing business.

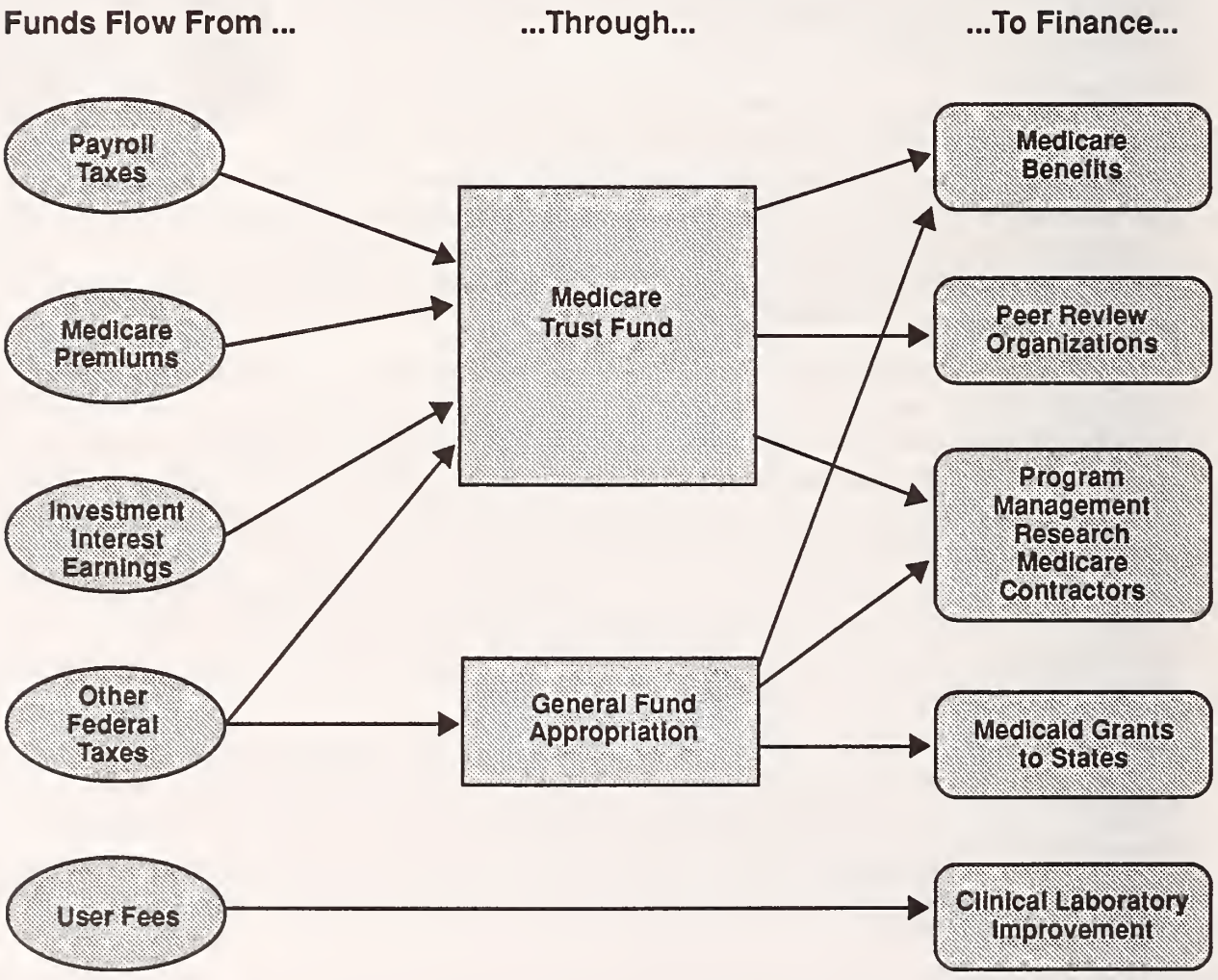
HCFA has also been a leader in quality indicator development. In 1996, working with avariety of groups, we have focused on developing better outcome measures for managed care plans. Working with the National Committee on Quality Assurance and a range of other groups, we participated in adapting HEDIS® (Health Plan Employer Data and Information Set) to both Medicare and Medicaid. Our goal is to collect only those measures that either help to improve the health status of beneficiaries or that help them make informed choices about insurance and treatment options. In the future, beneficiaries will have many more choices in health care delivery arrangements, such as health maintenance organizations, preferred provider organizations, and point of service plans. To decide which options are best for them, beneficiaries will need more information than is currently available. They will also need it in a user-friendly format.

During 1996, there was also increasing attention to the problems of the Medicare Hospital Insurance Trust Fund, from which we pay Medicare Part A claims for inpatient hospital, skilled nursing facility, hospice, and home health care. While there is no imminent danger that claims will go unpaid, the 1997 Trustees Report projects Trust Fund insolvency by 2001. As the Trustees have repeatedly urged, we must therefore work with the Congress to strengthen the Trust Fund in both the short and long terms.

These financial reports reflect HCFA's significant achievements and the agency's strong commitment to continuously improving financial management and beneficiary service. HCFA and its contractors process hundreds of millions of health care claims annually and oversee hundreds of managed care plans. We provide information to beneficiaries, monitor quality of care, and improve policies and procedures designed to render the best possible service to beneficiaries. Ensuring the financial integrity and efficiency of HCFA program administration is essential to meeting our responsibilities to the Trust Funds and to Medicare and Medicaid beneficiaries.

Bruce C. Vladeck
Administrator
July 1997

FINANCING OF HCFA PROGRAMS & OPERATIONS



Message from the Chief Financial Officer

As HCFA's Chief Financial Officer, I am pleased to report that in Fiscal Year 1996, we continued to make significant progress in improving financial management in HCFA. Prudent financial management is increasingly critical in this era of severely limited Federal resources. As an agency with one of the largest and fastest growing budgets in the Federal government, we in HCFA have a special obligation to ensure that we spend each dollar, whether for benefits or administration, as wisely as possible. Protecting the solvency of the Medicare trust funds is a basic element of our mission. This is especially important since the 1997 Report of the Hospital Insurance (HI) Board of Trustees projected that the HI Trust Fund will be depleted in 2001.

HCFA faces explosive growth in new providers, higher claims volume, and rapid growth in the 85 and older population, at the same time that we have to deal with Federal downsizing and limitations on discretionary spending. In 1996, we provided $206 billion in health benefits to more than 38 million Medicare beneficiaries and $91 billion in Medicaid Medical Assistance Payments to help finance care for more than 37 million Medicaid beneficiaries, while keeping administrative expenses at 1.1 percent of the total expenses. In order to responsibly administer programs in the future, HCFA must continue to seek operating efficiencies.

HCFA is actively transforming its computer technology to keep pace with the many changes in health care. We are working on initiatives that will provide a new information platform (software, hardware, and infrastructure) to pay for health care under the Medicare program, meet Medicare beneficiaries' customer service needs, and enable Medicare to deter costly fraud and abuse. The National Provider Identifier System is being developed to ensure that one number will be used for all Medicare billing.

We are committed to controlling and eliminating health care fraud, identifying inappropriate payments and recouping overpayments, while improving our program oversight activities. Our internal claims processes are very effective in pricing claims, determining eligibility, and identifying duplicate payments with a ninty-nine percent accuracy rate. However, Medicare, like other insurers, makes payments based on a standard claims form. Providers are supposed to retain supporting documentation and make it available upon request. In the 1996 audit, the Office of Inspector General has identified a statistically valid error rate that measures whether Medicare benefit payments were made correctly. Our preliminary review of the audit shows that a significant portion of the errors can be attributed to lack of or inadequate documentation on the part of providers who claimed payment.

We will be assessing the implications of this for both Medicare and the provider community and we will work with the provider community in addressing this problem. This measure of improper billing adds impetus to our ongoing efforts to improve program oversight activities.

HCFA Financial Statements *1996*

A major initiative launched during FY 1995. "Operation Restore Trust," was a demonstration targeting fraud and abuse in the delivery of skilled nursing facility, home health care, and durable medical equipment services in five States. These providers were among those with the highest error rate in the 1996 audit described above. Run jointly with the Office of Inspector General, the Department of Justice, and the Administration on Aging, Operation Restore Trust has aggressively pursued fraud by identifying and investigating questionable billing patterns, and developing a model for the sucessful prosecution of fraudulent or abusive providers or organizations. In 1996, this initiative identified nearly $40 million in savings with a budget of only $4 million.

Although Operation Restore Trust formally ended in March 1997, HCFA will continue to build on the successes of this 2-year project as we implement the Health Insurance Portability and Accountability Act of 1996. This act, also known as the Kassebaum-Kennedy bill, includes strong anti-fraud and abuse measures, including stabilized funding for this effort.

HCFA made important accomplishments in the accounting area in FY 1996. We processed 99.96% of HCFA's administrative payments on time in compliance with the Prompt Payment Act, and are developing a strategy to convert all payees to an electronic payment mechanism in order to comply with the Debt Collection Improvement Act of 1996. The costly, paper-intensive time card process was eliminated and replaced with the automated Time and Attendance Information Management System. We have begun conversion of the paper-based Treasury/Federal Reserve Bank Letter of Credit to Treasury's Automated Standard Application for Payment system, which currently disburses billions of dollars per month electronically to the Medicare Contractors for hospital insurance and supplementary medical insurance payments.

HCFA takes its financial management responsibilities very seriously. We are committed to improving our financial systems, accounting procedures, and reporting processes until we have the best financial management system in Government.

Anna Michelle Snyder

Michelle Snyder
Chief Financial Officer
July 1997

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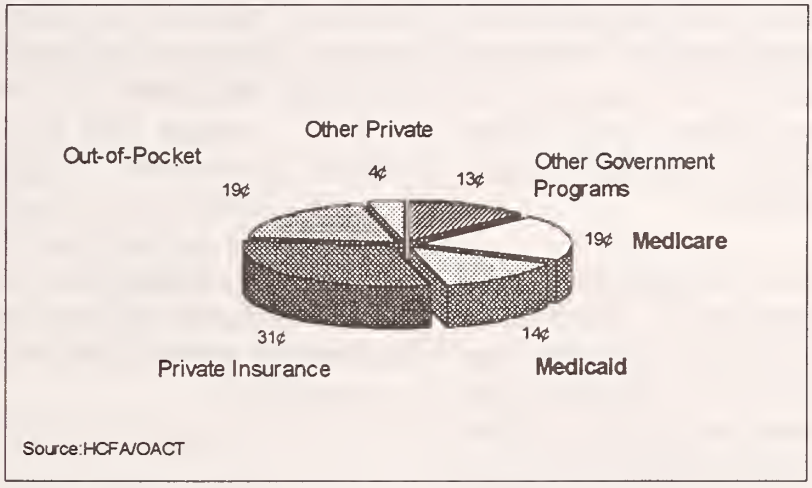
PROGRAM PROFILE

The Health Care Financing Administration (HCFA) is responsible for administering Medicare and Medicaid. HCFA is the largest purchaser of health care in the world. Medicare and Medicaid outlays represent 33.2 cents of every dollar spent on health care in the United States--47 cents of every dollar received by U.S. hospitals and 25.6 cents of every dollar received by other health care providers.



HCFA and the programs it administers outlayed $292 billion in fiscal year (FY) 1996, 18.7 percent of the total Federal budget. In addition to establishing rules for eligibility and benefit payments, paying 807 million Medicare benefits claims, and providing States with matching funds for Medicaid benefits, HCFA carries out many other important activities:

- HCFA is responsible for safeguarding the fiscal integrity of the Medicare and Medicaid programs and for assuring the safety and quality of medical facilities, providers, and suppliers by setting standards, conducting inspections, and certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found.

- HCFA conducts an extensive program of research through payment grants and demonstrations aimed at helping to improve the quality and affordability of health care, accessibility to care, and the efficiency of delivery and payment systems.

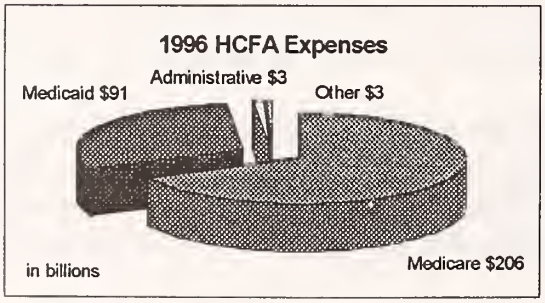
- HCFA maintains the Nation's largest collection of health care data and provides data and analytical services to the Congress, the Executive Branch, universities, and other private sector analysts and researchers.

- HCFA provides managed care choices to its beneficiaries and assures that managed care organizations meet quality, benefit, and financial integrity standards.

- HCFA, through the Clinical Laboratory Improvement Amendments program, helps assure the quality and reliability of laboratory testing for all Americans.

To understand the HCFA financial story, you need to understand two key financial terms. **Expenses** are one of the ingredients of the financial statements that begin on page 49. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivable and accounts payable on determining annual income. Wherever possible, expenses are the basis for discussions of HCFA's financial activity. **Outlays** refer to the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. Outlays are used in the discussions of HCFA's financial activity only when comparable expense data are not available.

- HCFA oversees State regulation of private Medigap insurance to ensure that Medicare beneficiaries are afforded important consumer protections.



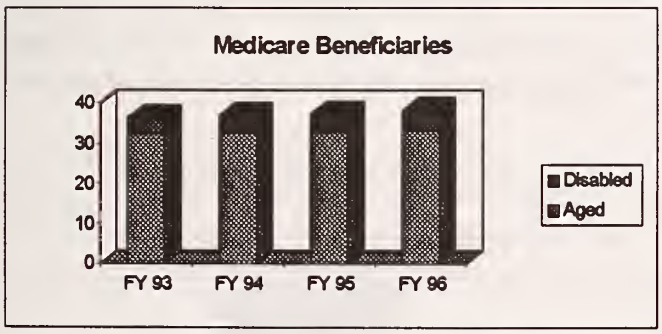
HCFA's expenses total $303 billion. The administrative expenses of $3 billion are less than 1.1 percent of the total. HCFA has 3,980 Federal employees, but carries out important operational activities through third parties: (1) 22,000 employees at 75 Medicare contractors have primary responsibility for processing Medicare claims, providing technical assistance to providers and responding to queries from beneficiaries (2) 34,000 State employees have primary responsibility for administering Medicaid, (3) 6,000 employees in 53 State survey agencies have responsibility for inspecting hospitals and nursing homes and other facilities to ensure that health and safety

standards are met, and (4) 1,600 employees at 53 Peer Review Organizations conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries. The Social Security Administration and other Federal agencies also provide thousands of other staff, either full or part time, for Medicare or Medicaid operations.

Of HCFA's 3,980 Federal employees, about 1,360 work in 10 regional offices around the country providing direct services to Medicare contractors, State agencies, providers, beneficiaries, and the general public. Approximately 2,620 of HCFA's employees work in Baltimore and Washington, D.C. providing funds to Medicare contractors, writing policies and regulations, developing more efficient operating systems, setting payment rates, managing programs to fight fraud, waste, and abuse, monitoring contractor performance, and assisting States and Territories with Medicaid issues.

MEDICARE

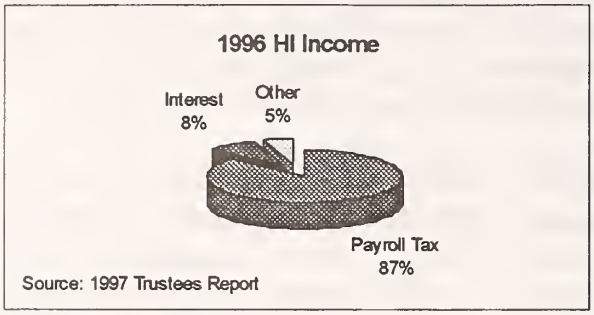
Title XVIII of the Social Security Act was established by the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people aged 65 and over. In 1972, the program was broadened to cover the disabled, people with end-stage renal disease, and certain others who elect to purchase Medicare coverage.



Medicare is a combination of two programs, each with its own enrollment, coverage, and financing--Hospital Insurance and Supplementary Medical Insurance. Since 1967, Medicare enrollment has increased from 19.5 million to 38.1 million beneficiaries, a 95 percent increase.

Hospital Insurance

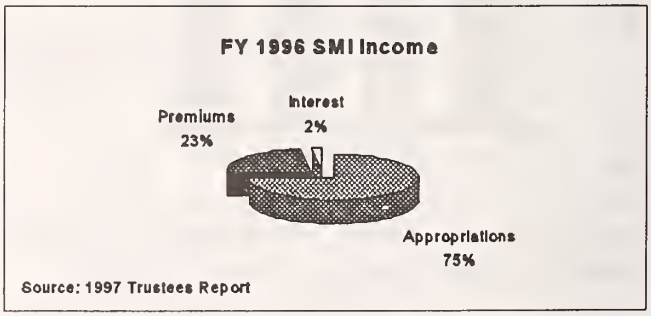
Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. HI pays participating hospitals, skilled nursing facilities, home health agencies, and hospice providers for covered services rendered to Part A enrollees.



Part A is financed through the HI Trust Fund, whose revenues come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). In 1996, the Medicare payroll tax rate was 2.9 percent of annual wages--employees and employers were each required to contribute 1.45 percent of employees' wages, with no limitation, to the HI Trust Fund. The self-employed paid the full 2.9 percent. In 1996, income from payroll taxes was $106.9 billion, income from interest was $10.2 billion, and all other income was $6.1 billion. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Income not currently needed to pay benefits and related expenses is held in the HI trust fund, and invested in U.S. Treasury securities. Hospital Insurance program expenditures exceeded annual income in calendar years 1995 and 1996. The 1997 Trustees Report of the Hospital Insurance Trust Fund projects depletion of the fund in 2001.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over and disabled people entitled to Part A. SMI covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and other services not covered by HI. SMI coverage is optional and subject to monthly premium payments by beneficiaries. About 95 percent of HI enrollees elect to enroll in SMI.

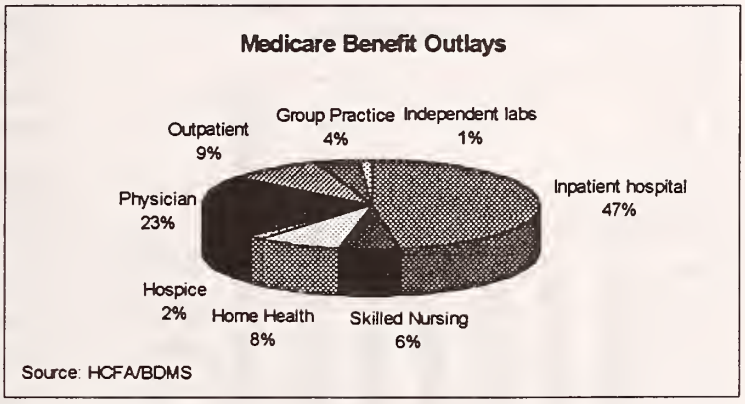


The SMI program is financed primarily by a general fund appropriation (Payments to the Health Care Trust Funds) provided by Congress and by monthly premiums paid by beneficiaries. The 1996 SMI premium, set by statute, was $42.50 per month. In FY 1996, beneficiary premiums accounted for $18.9 billion or 23 percent of SMI revenues. The remainder was provided by $61.7 billion from the general fund appropriation, and $1.6 billion in interest.

Medicare Benefit Payments

Medicare benefit payments accounted for a total of $206 billion in expenses. HI benefit expenses ($139.2 billion), including payables, rose 27.2 percent; SMI benefit expenses ($66.6 billion) rose 8.1 percent.

Inpatient hospital services now account for about 76 percent of HI benefit outlays. Hospital payment growth was driven by both increased hospital admissions and higher costs per admission. Spending for skilled nursing facility care and home health care continued to rise at a much faster rate, but these services constitute a much smaller portion of total HI outlays.



Inpatient hospital spending accounted for almost 70 percent of the increase in HI benefits outlays. Home health spending comprised 13.1 percent of total HI spending (eight percent of total Medicare spending) and 16 percent of the FY 1996 increase.

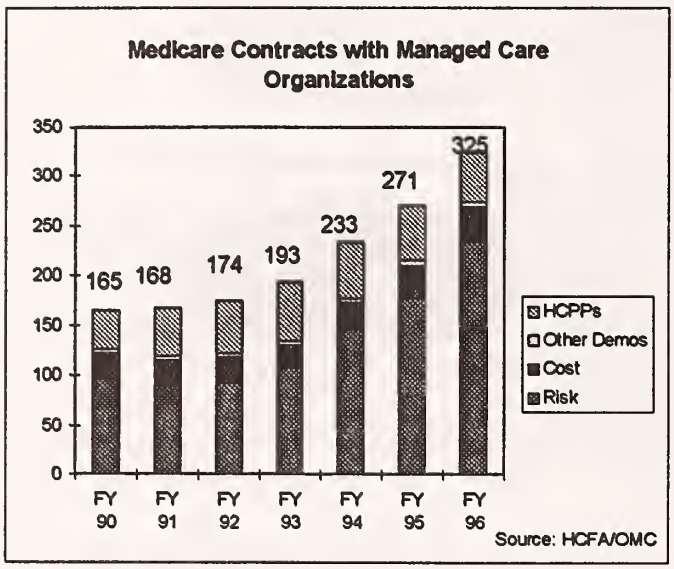
SMI benefit outlays grew at 6.2 percent. Physician services, the largest component of SMI spending, grew 3.3 percent and accounted for more than 35 percent of the increase in FY 1996 SMI benefits. Though only constituting 24 percent of SMI benefits, payments for outpatient services accounted for nearly 35 percent of FY 1996 SMI growth.

HI benefit outlays per enrollee rose 7.7 percent to $3,294. However, fewer than 22 percent of HI enrollees received benefits in FY 1996--thus, spending per enrollee receiving services was much higher: $15,235. SMI benefit outlays per enrollee increased 4.4 percent to $1,867. Spending per enrollee receiving services was $2,215.

Managed Care

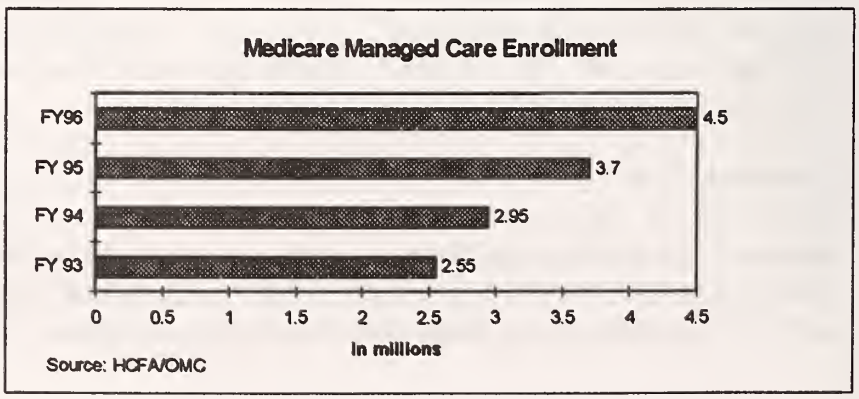
Medicare beneficiaries may choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional fee-for-service arrangements. In general, a managed care organization consists of its own providers or a network of health care

providers (physicians, hospitals, skilled nursing facilities, etc.) that agree to arrange for health care services for its members. The number of Medicare contracts with managed care organizations has increased from 165 in FY 1990 to 325 contracts in FY 1996.



Managed care plans can serve Medicare beneficiaries through three types of contracts: risk, cost, and health care prepayment plans (HCPPs), and certain demonstration projects. Risk plans are paid a per capita premium set at approximately 95 percent of the projected average expenses for fee-for-service beneficiaries in a given county. Risk plans assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare-covered services. Most plans offer additional services such as prescription drugs and eyeglasses. Cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services but do not provide the additional services that some risk plans offer. HCPPs are paid in a manner similar to cost plans but generally cover only Part B Medicare services. Any Medicare beneficiary, except those with ESRD, may join a managed care organization. Medicare beneficiaries can enroll or disenroll in a managed care plan at any time and for any reason with only 30 days notice.

Since 1993, there has been unprecedented growth in the number of Medicare beneficiaries enrolled in managed care plans. In September 1996, approximately 4.5 million Medicare beneficiaries, or 12 percent of the total

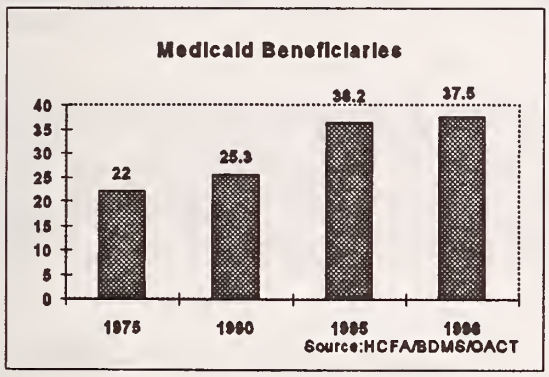


Medicare population, were enrolled in a managed care plan. This represents a 76 percent increase in managed care enrollment since 1993.

Managed care expenses accounted for $19.1 billion of the total $206 billion in Medicare benefit payment expenses in FY 1996. The growth of Medicare managed care creates new challenges for HCFA, particularly in the areas of quality assurance and beneficiary protections.

MEDICAID

Medicaid is the means-tested health care program for low-income Americans, administered by HCFA in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, however, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and mentally retarded persons requiring long term care. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to 37.5 million in 1996, an increase of 275 percent. Approximately six million people are dually entitled, that is, covered by both Medicare and Medicaid. Medicaid recipients are now 13.8 percent of the total civilian population.



Under Medicaid's division of responsibilities, HCFA provides matching payment grants to States and Territories.

- State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 1996, the Federal matching rate among the States ranged from 50 to 78 percent, with a national average of 57 percent.

- Federal matching rates for various State and local administrative costs are set by statute, and in 1996 averaged 56 percent.

Medicaid grants are funded by Federal general revenues provided to HCFA through the annual Labor/HHS/Education Appropriations Act. There is no cap on Federal matching payments to States.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include:

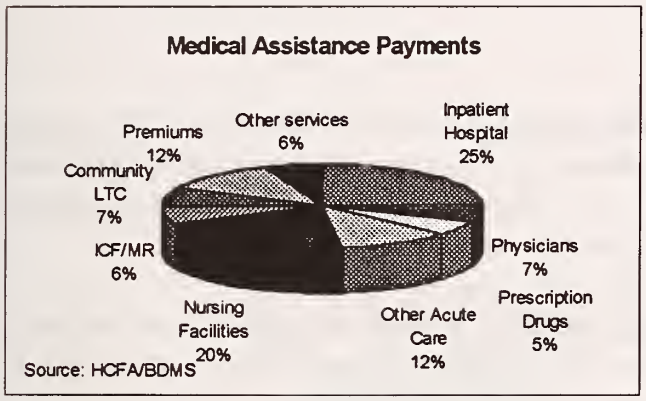
- Providing coverage to persons receiving Aid to Families with Dependent Children (AFDC) (prior to the repeal of AFDC in the Personal Responsibility and Work Opportunity Reconciliation Act enacted August 22, 1996), Supplemental Security Income, low income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and

- Covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning, nursing facility services, and health screening for children under age 21.

State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to individual State circumstances and priorities. Accordingly, there is a wide variation in the services offered by States. For example, 27 State Medicaid programs cover psychological services, 49 cover adult dental services, and seven cover services of medical social workers.

Medicaid helps reduce infant mortality and improve maternal and infant health by bringing more eligible pregnant women into pre-natal health care and more infants into early health supervision. States can pursue these goals by expanding eligibility, streamlining eligibility processes, conducting outreach, improving provider recruitment and retention, and adding new service delivery options or enhancements.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program is a preventive and comprehensive health program for Medicaid-eligible individuals under the age of 21. It creates a framework under which Medicaid-eligible children can receive regular preventive health screenings and a range of follow-up services that may be broader than those available to Medicaid-eligible adults.

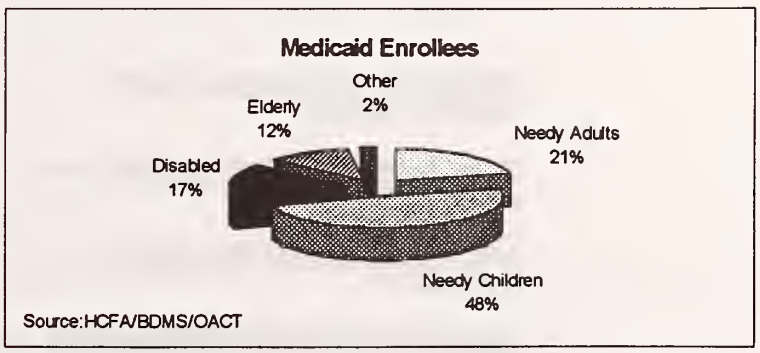


Medicaid is the largest single source of payment for health care services for persons with AIDS. Medicaid now serves about 50 percent of all AIDS patients and pays for the health care costs of over 90 percent of the children and infants with AIDS. Twenty-five percent of the total cost of direct medical care for AIDS patients is met through Medicaid. Total Medicaid spending for AIDS care and treatment in FY 1996 is estimated at nearly $3.5 billion. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

Payments

Under Medicaid, State payments for both medical assistance (MA) and administrative (ADM) costs are matched with Federal funds. In FY 1996, State and Federal ADM outlays were $6.7 billion--only 4.1 percent of the total Medicaid outlays. State and Federal MA outlays were $154.9 billion, or 95.9 percent of total Medicaid outlays, an increase of 3 percent over FY 1995. HCFA's Medicaid expenses totaled $91.5 billion.

Enrollees



An estimated 37.5 million Medicaid enrollees receive services. Children comprise 48 percent of Medicaid enrollees receiving services, but account for only 15 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 29 percent of Medicaid enrollees receiving services, but accounted for 60 percent of program spending. The elderly and disabled use more services in all categories, particularly nursing home services.

Managed Care

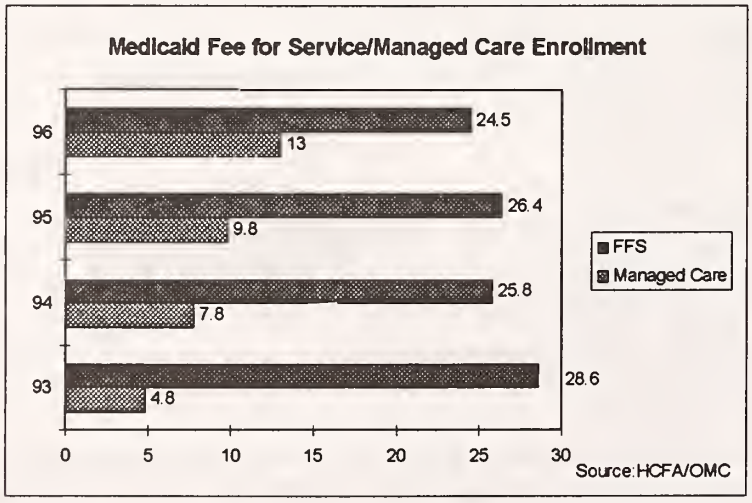
Many States are pursuing managed care as an alternative to the fee-for-service (FFS) system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications.

HCFA and the States have worked in partnership to offer managed care to Medicaid beneficiaries. Medicaid law provides for two kinds of waivers of existing Federal statutes to allow for the implementation of managed care--

1) State health reform waivers - Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects, and

2) Freedom of choice waivers - Section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow States to develop innovative managed health care delivery or reimbursement systems.

Most States have taken advantage of these waivers to introduce managed care plans tailored to their State and local needs, and there are currently 14 State-wide managed care plans. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 5 percent in 1993 to more than 30 percent by September 30, 1996.



Overview

Performance Measures

Chapter 2

Performance Measures

The Health Care Financing Administration (HCFA) developed and implemented a comprehensive Strategic Plan in February 1994. Its seven goals reflect the mission and vision of the agency, and provide a framework for moving toward the future. With the dual responsibilities of serving the Medicare and Medicaid beneficiaries while also protecting taxpayer dollars, HCFA is repositioning itself to become a more effective purchaser of health care services. This new focus is essential because of the increasing cost of health care, shrinking resources, and changing public attitudes. Our response is to restructure HCFA to focus on improving the quality of beneficiaries' health care and safeguarding the fiscal integrity of the Medicare and Medicaid programs without necessarily increasing government regulation or control.

HCFA has devoted a significant amount of staff resources toward implementation of the Government Performance and Results Act (GPRA). In addition to developing a Strategic Plan, in 1995, measurable activities were identified and a series of performance measures were proposed. In 1996, we began feasibility assessments of these performance measures. At the same time, HCFA completed a thorough review and assessment of HCFA's organizational structure to improve our responsiveness to our customers and to assess whether or not it is aligned in a way to implement the Strategic Plan and to effectively meet the demands of the future.

HCFA is now updating the Strategic Plan. The goals and objectives developed in our original Strategic Plan, the six roles defined for the new organizational structure, and benchmark strategic plans from both the private and public sectors form the basis for this effort. The six roles listed below will be the drivers in the strategic plan updating process.

- Protect, serve, and advocate for our beneficiaries
- Provide information to beneficiaries, partners, and the public
- Provide leadership in the broader public interest
- Be a prudent purchaser of health care
- Be an efficient and effective program administrator
- Promote quality-centered health care through continuous improvement and quality management

As we complete the feasibility assessments of the performance measures developed under our current Strategic Plan we will begin collection of base-line data and further analysis of its

validity, reliability and usefulness. The current performance measures for significant program activities will be used to focus our resources on the Strategic Plan Goals and the six core budget themes in our FY 1998 budget proposal.

The performance measures will continue to be tracked by the agency during the development of the revised Strategic Plan. Where appropriate, new performance measures will be identified. The final set of performance measures will be used for the development of our first Annual Performance Plan and provide linkage between HCFA's Strategic Plan and our FY 1999 budget. Our GPRA implementation plan time line and milestones include plans to consult with Congress, the Department, our partners and stakeholders.

Overview

Initiatives and Accomplishments

Chapter 3

Initiatives/Accomplishments

The Initiative and Accomplishments for 1996 are keyed to the seven goals of HCFA's current Strategic Plan.

GOAL 1 - Build a high-quality, customer-focused team.

While health care expenditures have been increasing at rapid rates, HCFA's program operating costs have actually declined after taking inflation into account. The aging of the population (resulting not only in an increase in program enrollment but also increased use of medical services and, thus, more claims for payment), increasing numbers of disabled beneficiaries, and a proliferation of providers, such as managed care plans and home health agencies, have all put tremendous pressures on HCFA's operational costs. In spite of these pressures, HCFA has achieved efficiencies which have held Program Management spending virtually level since FY 1993. The rapidly changing health care industry and a need to ensure we have an effective two-way communication strategy with our primary customer, the beneficiaries, has driven much of the activity during FY 1996.

Organizational Changes

Numerous organizational changes were completed this year. HCFA completed the internal restructuring called for in the National Performance Review at Central Office, while the Regional Offices gained experience operating as consortia. In addition, we established specialized regions for monitoring durable medical equipment claims processing and the Peer Review Organization program. We recently completed a comprehensive review and assessment of HCFA's organizational structure to improve our responsiveness to our customers. An Administrator-appointed team, the HCFA of Tomorrow or HOT Team, conducted a thorough review of the Agency's structure to assess whether or not it is aligned in a way to effectively meet the demands of the future. The HOT Team has made recommendations for significant changes which will be reflected in the revised Strategic Plan and the new HCFA organizational structure.

Technological Improvements

HCFA has made major technological improvements with the implementation of the new Local Area Network (LAN)-based environment, internal communications via the Intranet, and agency-wide access to the Internet. Relational databases and new desktop tools and dissemination vehicles soon will allow HCFA employees to receive and distribute information right from their workstations.

Teamwork

The emphasis on teamwork is reflected in the establishment of teams representing components who each have a stake in a particular issue. One example is the regulation teams where a draft regulation is rewritten by a team with full input by all members, rather than through a sequential comment and clearance process. Another example is the Agency-wide Quality Initiative Team, which is developing and articulating a comprehensive quality strategy for HCFA that includes all of the different quality initiatives and activities underway throughout the Agency.

Partnering

Extensive efforts have been initiated to include the States as well as our many contractors in the planning and implementation of changes to our programs. Federal and State agencies working in tandem make better use of our resources as regulators, and those of the providers, by eliminating redundancy and by recognizing the different types of expertise that exist at the Federal and State regulatory levels, e.g., we are communicating closely with the States as we pursue the Medicaid aspects of Welfare Reform implementation. We are actively engaged in developing partnerships with the States to improve the oversight of managed care plans. One of the real pluses of this initiative is that, as we communicate with the States and the plans about regulatory processes, we are educating each other, bringing people together to talk and share experiences, with the common goal of using our resources wisely.

Goal 2 - Ensure programs and services respond to the health care needs of beneficiaries.

The HCFA On-Line initiative establishes our overall communications strategy by providing customer, partner and stakeholder feedback through a variety of projects. Examples include a number of continuous improvement activities to conduct outreach focus groups with beneficiaries to determine their information needs and how they want the information

presented, measuring beneficiary satisfaction with access to care and disseminating that information to HCFA policy makers, and a teleservice center pilot designed to test if responses to beneficiary telephone inquiries can be improved by providing the service representative with access to multiple Medicare-related data systems.

Defining Beneficiary Needs

The Medicare Current Beneficiary Survey (MCBS) helps HCFA ensure that its programs and services respond to the health care needs of our beneficiaries in a number of ways. The MCBS directly involves beneficiaries in defining their health care needs by interviewing a large representative sample of them about their health status and physical functioning, access to care, and satisfaction with the Medicare services they use. MCBS also aids in HCFA's educational and outreach initiatives by collecting information on which methods are best suited to reaching specific subgroups of the Medicare population.

Service Partnerships

We have continued to develop new partnerships with organizations such as State Insurance Commissioner Offices, purchasing coalitions and major health care network providers. We created an external newsletter, "Health Watch," which is designed to keep partners, providers, and other stakeholders in Medicare and Medicaid programs aware of both recent and upcoming events and issues of interest. The Medicaid Bureau, in response to Vice President Gore's "Fatherhood Initiative," has contracted with Academy Concepts, Inc. to conduct three focus groups to identify barriers that prevent custodial parents and non-custodial parents from participating more fully in health care decisions for their children. The Office of Long Term Care Services in the Medicaid Bureau has been actively involved with State agencies, advocacy and consumer groups in making the process of applying for home and community based services waivers a less formidable task than it has been in the past.

Responding to Beneficiaries

Other programs that support our goal to respond to beneficiaries' needs include establishing a Medicare Information Center, "The Medicare Store," which is an outreach center located in a shopping mall; establishing beneficiary services workgroups; and visits to a number of private and public organizations to use as benchmarks for customer service and benefit integrity. In addition, we translated a significant number of publications to foreign languages, and led the development of a strategy to evaluate alternative telemedicine approaches.

We're working to reduce the confusion and paperwork that often arises from the Explanation of Medicare Benefits, our claims payment notice. The new Medicare Summary Notice is an easy-to-read statement that will be issued monthly based on services received the previous month. Testing of the notice is being conducted in Texas and Florida.

We are continuing our efforts to make Medicare and Medicaid related material electronically available on the web site to beneficiaries, contractors, providers, and HCFA's partners. We have tested Health Talk Interactive to make health information readily available to beneficiaries, and partnered with the American Association of Retired Persons on managed care information meetings with seniors.

Managed Care Protections

Medicare managed care has become increasingly popular among Medicare beneficiaries. HCFA is committed to maintaining current law protections which include the beneficiaries' ability to disenroll on a monthly basis, grievance and appeal rights, and limits on out-of-pocket expenses. We also plan to improve the monitoring and enforcement of these protections and the comparative information available to Medicare beneficiaries about managed care plans. HCFA is making information more widely available through the Medicare Handbook, the Managed Care Resources Directory, a Medicare managed care pamphlet, and a letter explaining to beneficiaries their rights under Medicare managed care.

Goal 3 - Promote improved health status of beneficiaries.

Through Peer Review Organizations, State Agencies, and others, HCFA collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both fee-for-service and managed care settings. These collaborative projects often employ a sequential process which includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

HCFA has been a leader in the development of quality indicators. Our goal is to collect only those measures that we believe will help to improve the health status of our beneficiaries or which can help them make informed choices about their health care. This is an area in which we have worked very closely with the private sector, consumers, and providers to develop new tools.

Outcome Measures for Managed Care

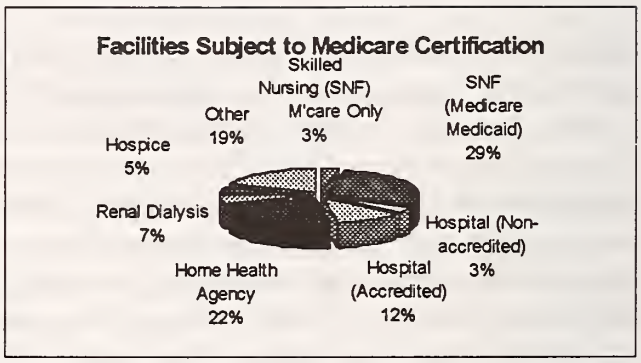
HEDIS® - In 1996, we focused on creating better outcome measures for managed care. We started with a system of quality measures called HEDIS®, the Health Plan Employer Data and Information Set, developed by the National Committee for Quality Assurance (NCQA). Then, working with the NCQA, the States, managed care plans, and consumers' organizations we adapted the commercial HEDIS®, first to Medicaid and then to Medicare. Our emphasis was on addressing the special concerns of these populations, which are very different from those of the commercial population for which the measures were first developed. Our objective has been to create outcomes measures that could tell us more about the health outcomes of our beneficiaries. The result is HEDIS® 3.0--complete with measures for Medicaid and Medicare. Medicare plans will be required to comply with the data requirements starting in 1997. For Medicaid, the States have the option of utilizing the measures.

FAcct - HCFA is on the Board of Directors of the Foundation for Accountability (FAcct), a new nonprofit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. The Board includes a wide range of public and private sector purchasers, consumer groups, and organized labor. The goal of this nonprofit group is twofold: (1) to develop new outcome measures for value purchasing and health plan accountability; and (2) to serve as a clearinghouse of relevant information derived from measures for consumers, purchasers, and managed care plans. FAcct also plans to provide education to help the public make informed decisions when choosing a health plan. FAcct has tremendous potential right now because of the need for better plan accountability and greater purchaser and consumer control in managed care. In 1996, FAcct endorsed three condition-specific outcome measures which HCFA is interested in testing. They are diabetes, depression, and breast cancer. FAcct's consumer oriented perspective provides a necessary counterpoint to provider-oriented quality assurance organizations.

Survey and Certification Program

The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. HCFA administers agreements with State survey agencies to conduct onsite facility inspections. Only certified providers and suppliers are eligible for Medicare payments. A companion Medicaid State certification program is funded through the Medicaid appropriation.

In FY 1996, State surveyors conducted 24,092 inspections and cited 19,460 facilities for deficiencies. Over 57,000 facilities are certified.



In July of 1995, HCFA implemented the enforcement portion of the Omnibus Budget Reconciliation Act (OBRA) of 1987 nursing home reforms. This regulation, which identifies appropriate sanctions, was the most controversial portion of the reforms and was implemented only after lengthy consultation with everyone involved. The nursing home reforms, most of which were implemented in 1990, significantly elevated standards for nursing home care, requiring better monitoring of residents' health status, improvements in the quality of residents' daily lives, and better training of nurse aides, to name a few of the provisions. This last regulation gives the States a variety of ways to enforce all of the OBRA requirements, ranging from fines to termination of Medicare or Medicaid reimbursement.

Consumer Information Program

HCFA's Consumer Information Program (CIP) is an example of another tool to improve the health status of our beneficiaries. Our first major national campaign promoting influenza shots for Medicare beneficiaries was completed prior to the 1994 flu season. We are currently running the third annual Flu 2000 campaign, in partnership with the Centers for Disease Control and Prevention, to help achieve the goal of a 60 percent flu immunization rate for Medicare beneficiaries by the year 2000. In addition, HCFA has undertaken the Horizons Project, which is designed to improve access and the health status of Hispanic, African-American and disadvantaged and/or vulnerable Medicare beneficiaries. In collaboration with historically black colleges and universities, we are developing and implementing community-level intervention strategies to achieve the project's goals. The initial focus is to improve the influenza vaccination rates of African-Americans and to build the capacity to improve their health status. Other national CIP campaigns include promoting mammography benefits for women over 65, and services for Medicaid-eligible pregnant women who are HIV positive.

We have projects underway to reduce death or disability from heart attack by providing educational interventions for health professionals, patients, and the public to minimize delay in seeking treatment. In addition, HCFA has contracted with the Center for Health Systems Research and Analysis to test the Comprehensive Health Enhancement Support System (CHESS). CHESS is an interactive computer program that provides information and online

discussion groups to help female Medicare beneficiaries with breast cancer deal with their illness and make decisions concerning their treatment options.

End Stage Renal Disease Initiatives (ESRD)

As the single largest purchaser of ESRD treatment services in the United States, HCFA has a critical responsibility for the quality of care delivered to these patients. Our goal is to improve the quality and accessibility of the services, while keeping an eye on costs. We are building a comprehensive, integrated approach to the quality management process for ESRD on a number of fronts by initiating a new focused survey process, enhancing the quality improvement projects of the ESRD networks, and improving the working relationships between Networks and State Agencies with quality improvement as our goal. "It's Your Life...Know Your Number!" is an ESRD patient brochure designed to educate ESRD patients about their illness so they can determine if the hemodialysis treatments they receive are adequate. Other HCFA projects target improving the anemia status of dialysis patients and the early detection and treatment of diabetic retinopathy in Medicare beneficiaries with diabetes.

Goal 4 - Be a leader in health care information resources management.

HCFA's data bases are the largest and most complete source of health care information in the United States. In 1996, HCFA unveiled a new, expanded web site <http://www.hcfa.gov> that offers data, statistics, publications (including our annual financial report), and other material for our beneficiaries, contractors, and the general public.

Medicare Transaction System (MTS)

To become a more effective administrator of Medicare and Medicaid, we are working to implement a new information platform (software, hardware, and infrastructure) to pay for health care under the Medicare program, meet Medicare beneficiaries' customer service needs, and enable Medicare to deter fraud and abuse called MTS. The MTS will focus initially on managed care transactions. We are also continuing our efforts to consolidate the Medicare payment systems into one standard system for hospital bills and a standard system for physician bills, each with an integrated accounting system. This will simplify current operations in preparation for the eventual implementation of the single MTS system.

Data Improvement Initiatives

Other data improvement activity involves working with the health care industry to standardize data and forms, as well as methods for receipt and transmission of data, and developing and implementing a national Health Care Quality Improvement Project (HCQIP) surveillance system to utilize data collected by the Peer Review Organizations. We are also testing the system to implement the automation of a Minimum Data Set which will collect information on 1.5 million nursing home residents residing in more than 17,000 nursing homes. We published a proposed rule of March 10, 1997, that when fully implemented, will result in collecting core assessment data on home health patients as well. We have begun development of the National Provider Identifier System which will ensure that one number, the National Provider Identifier, will be used for all Medicare billing. With unique provider identifiers we will have enhanced ability to verify information for each provider seeking to bill Medicare.

Goal 5 - Promote fiscal integrity of HCFA programs.

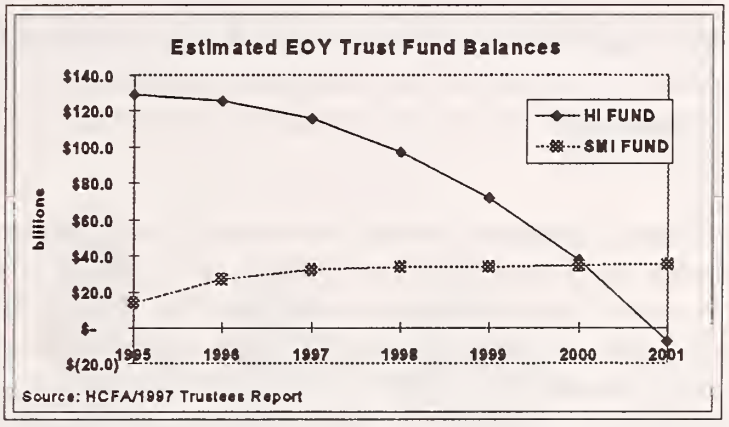
HCFA is the largest purchaser of health care in the United States, and is transitioning from a payer organization to a "prudent purchaser of health care services." This transition is being made through collaboration with a number of large purchasers to explore opportunities for obtaining the best value in quality, cost-effective health care services for our beneficiaries. To that end, we have created an external customer profile -- a new, user-friendly system which will enable HCFA to deal with our provider groups and advocacy communities and will enhance coordination of customer correspondence, report gathering and research.

Along with other large purchasers of health care, we are developing purchasing strategies that will help us not only meet our goal of providing high quality health care to both Medicare and Medicaid beneficiaries, but also provide the best value in services for the dollars we spend. This is vital in view of the current funding situation.

Status of the Trust Funds

The 1997 Report of the Hospital Insurance (HI) Board of Trustees projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2001. The Trustees (the Secretaries of the Treasury, Health and Human Services, Labor, and two public trustees) recommended that legislative action be taken to bring the HI program into actuarial balance. The Supplementary Medical Insurance (SMI) Board of Trustees reported that the SMI program is actuarially sound, but noted that the rapid rate of program outlay growth requires legislative action to control SMI costs.

The end of year (EOY) trust fund balances are shown in the chart, and discussed in greater detail in the "Challenges" section.



Payment Safeguards

The Medicare contractors carry out a range of activities collectively known as "payment safeguards" to prevent, detect, and recover inappropriate Medicare benefit payments. Over the past several years, these payments have returned significant savings to the trust funds. Payment safeguards include:

- Medicare Secondary Payer (MSP)--activities that identify instances where an insurance company may be the primary payor, prior to payment of the claim by Medicare or as a recovery after payment by Medicare,
- Medical Review and Utilization Review (MR/UR)--activities that ensure medical services provided are covered by Medicare and are necessary and appropriate,
- Audits of Medicare providers, and
- Fraud and abuse detection and prevention.

The magnitude of Medicare payment safeguard savings illustrates that funding of payment safeguards is a sound investment. Each appropriated payment safeguard dollar leads to savings of 13 benefit dollars.

Operation Restore Trust

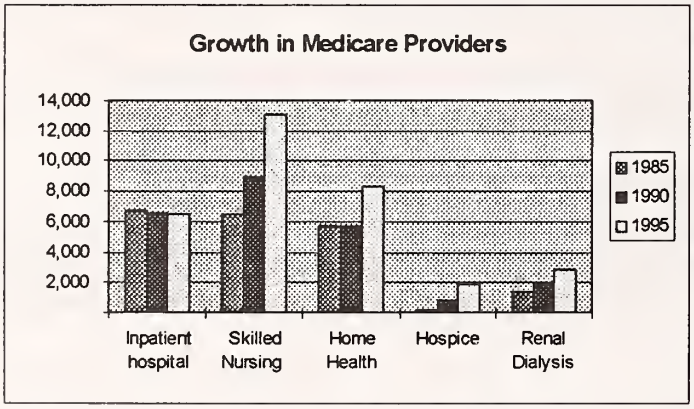
A major initiative launched during FY 1995 and continuing throughout FY 1996, "Operation Restore Trust" targets fraud and abuse in skilled nursing facility, home health care, and durable medical equipment services in five States. Together with the Office of Inspector General, the Administration on Aging, the Department of Justice, and the State Medicaid

fraud units, HCFA is working to identify and investigate questionable billing patterns, and to develop a model for the successful prosecution of fraudulent or abusive providers or organizations. In 1996, this initiative identified nearly $40 million in savings with a budget of $4 million.

Although Operation Restore Trust formally ended in March 1997, HCFA continues to build on the successes of this 2-year demonstration project as we implement the Health Insurance Portability and Accountability Act of 1996. This act includes strong anti-fraud and abuse measures, including stabilized funding for this effort. In addition, the Debt Collection Improvement Act of 1996 will facilitate collections by the Federal Government and encourage the coordination of information within and among Federal agencies.

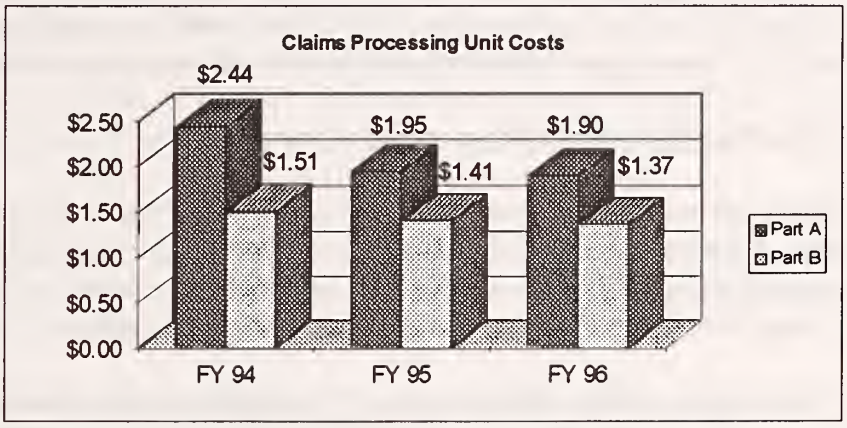
Other Anti-fraud Initiatives

HCFA has devoted greater emphasis on Medicaid fraud through the Medicaid Council and the Medicaid Network. These projects help coordinate increased cooperation with States and other entities. HCFA's partnerships with States' Surveillance and Utilization Review Systems and Medicaid Fraud Control Units have facilitated detection, referral, and prosecution of Medicaid fraud.



HCFA is actively transforming its computer technology to keep pace with the many rapid changes in the health care field and the explosive growth in new providers. In addition to the MTS and National Provider Identifiers System discussed above, we have implemented the National Supplier Clearinghouse (NSC), which is designed to enroll suppliers of durable medical equipment and supplies in Medicare and to help exclude fraudulent providers who submit applications for participation. In 1996, the NSC revoked almost 600 oxygen provider numbers for fraudulent information. We also use the National Practitioner Data Bank, maintained by the Public Health Service, to share data on physicians and other health professionals involving malpractice payments.

Goal 6 - Create excellence in the design and administration of our programs.



HCFA's total administrative expenses were $3.17 billion in FY 1996, slightly less than FY 1995 administrative expenses. This represents 1.1 per cent of total expenses and includes the expenses of 75 Medicare contractors who process and pay benefit claims, respond to beneficiary and provider inquiries, review claims for medical necessity and indications of fraud and abuse, audit providers, conduct hearings and appeals, and perform other claims-related work. There are 43 fiscal intermediaries who handled 142 million HI (and some SMI) claims at an average cost per claim of $1.90, while 32 carriers handled 665 million SMI claims at an average cost per claim of $1.37.

HCFA continued to bridge the growing gap between workload and contractor funding through unit cost reduction. Contract negotiations, special initiatives, and contractor evaluation policies stressed the importance of lowering unit costs in individual contracts and reducing variation among contractors. The continued use of electronic claims submission has enabled HCFA to reduce unit costs overall.

Goal 7 - Provide leadership in the continuing evolution of the health care system.

The goal of HCFA's research, demonstration, and evaluation program is to provide timely, reliable information required for informed and rational decision making in the Medicare and Medicaid programs.

This goal was pursued through four primary objectives: 1. To monitor and evaluate performance of HCFA programs in terms of access, quality, efficiency and costs; 2. To further refine existing payment systems and to develop new payment, cost containment, and financing systems; 3. To develop new approaches to meet health care needs of vulnerable populations; and 4. To develop information systems to improve consumer choice and health status.

Exploring Methods of Payment: Medicare

One of the most difficult issues for Medicare as a purchaser of health care is how to pay for managed care. Since the Medicare program is limited by law in its ability to use alternative ways of paying for health care, we have used our authority to set up demonstration projects around the United States to test alternatives for the future.

The Medicare Choices Demonstration is an experiment in a number of promising managed care markets and rural areas to provide expanded choices to our beneficiaries through new delivery systems, such as Preferred Provider Organizations and Provider-Sponsored Organizations. This demonstration will move us toward developing solutions to a wide range of implementation issues, including risk sharing, payment methods, certification and licensure requirements, and quality monitoring and performance systems. A component of the demonstration is the development of quality measurements systems that will use encounter data.

Exploring Methods of Payment: Medicaid

In the Medicaid arena, many States have been actively studying new ways to implement managed care, taking advantage of HCFA's authority, through waivers, to permit new service and payment designs. Medicaid's home and community-based services waiver program affords States the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals.

Section 1115 of the Social Security Act provides broad discretion to waive certain laws pertaining to Medicaid in order to conduct experimental, pilot or demonstration projects. These demonstrations are frequently aimed at serving more low-income and uninsured people while saving money through new program efficiencies. At the end of FY 1996, HCFA has approved 14 statewide managed care plans and numerous sub-state demonstrations expanding coverage to over eight million persons, many of whom were previously uninsured.

Vulnerable populations

Since Medicare is the dominant payor in rural areas, some of HCFA's policies and demonstrations are designed to test an effective rural response. Rural areas have difficulty attracting and retaining physicians because of lack of complete medical facilities, professional isolation, limited support services, insufficient continuing medical education, and excessive work and time demands. Several of HCFA's demonstration projects, such as the Rural Primary Care Hospital Program, Medicare Choices, and an upcoming telemedicine program target rural health.

In 1996, socioeconomic data from the 1990 U.S. Census were linked to Medicare data for the first time. Analyses show that low income beneficiaries are at risk of higher mortality and have greater barriers to preventive services and primary care.

Six grant awards were made to Historically Black Colleges and Universities to conduct health services research activities focused on improving access to and use of health care services by African-American beneficiaries.

Overview

Challenges

Chapter 4

Challenges

STATUS OF THE TRUST FUNDS

Hospital Insurance (HI)

The 1997 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund projected, under intermediate actuarial assumptions, that the HI Trust Fund will be depleted in 2001.

The Trustees (the Secretaries of the Treasury, Health and Human Services, Labor, and two public trustees) recommended the earliest possible enactment of legislation to reduce growth in the HI program costs and extend the date of exhaustion of the HI trust fund. We see this as a two-stage process in which imminent depletion of the HI trust fund is remedied this year. The performance of alternative modes of treatment and service delivery over the next few years, in both quality and cost, will provide new information that will contribute to better legislative decisions regarding the long-range outlook for HI.

Supplementary Medical Insurance (SMI)

The SMI trust fund is expected to remain adequately financed into the indefinite future, but only because current law provides for the establishment of program financing each year based on an updated calculation of expected cost per SMI beneficiary. Premium income is expected to cover a declining share of program costs. Premiums accounted for 23 percent of revenue in calendar year 1996 and are estimated to account for 16 percent in calendar year 2006 and a progressively lower share thereafter. Because of the past and projected rapid growth in the cost of the program, the Trustees urged the Congress to take appropriate steps to more effectively control SMI costs.

The Demographic Challenge

Demographic trends pose a long-term challenge to the sustainability of the trust funds. There are expected to be 3.6 workers per HI beneficiary when the baby boom generation begins to reach age 65 in 2010. Then the worker/beneficiary ratio is expected to decline to 2.3 in 2030 as the last of the baby boomers reaches age 65. The ratio is expected to continue declining thereafter (but more gradually) as life expectancy continues to lengthen.

HI expenditures are projected to grow rapidly as a fraction of workers' earnings, from

3.5 percent in 1996 to about 11.5 percent in 2070. As a fraction of the Gross Domestic Product (GDP) expenditures would grow somewhat more slowly, from 1.7 percent in 1996 to about 5 percent in 2070. SMI expenditures are expected to continue to grow faster than the economy as a whole. SMI outlays were almost one percent of the GDP in 1996 and are projected to grow to about 2.5 percent by 2020.

DISBURSEMENTS AS A PERCENT OF GDP

Calendar Year	HI	SMI	Medicaid	Total
1996	1.72	0.94	2.0	4.66
2000	1.92	1.11	n.a.	@5.03[1]
2005	2.18	1.39	2.7	6.27
2020	3.18	2.54	n.a.	@8.72[1]
2070	4.96	3.42	n.a.	@11.38[1]

[1] Medicaid is not projected as a percent of GDP past the year 2005. The total shown here assumes that Medicaid is held level at 2 percent of GDP in the year 2000, and 3 percent of GDP for 2020 and 2070.

PRUDENT PURCHASING

Although increasing numbers of beneficiaries are choosing to enroll in managed care, the vast majority of beneficiaries are still in fee-for-service. While private sector purchasers or health services have developed a variety of innovative ways to pay for health services, HCFA, the largest purchaser of health services in the world, is limited in its ability to adapt to today's marketplace by statutory payment and administrative pricing provisions. Despite these limitations, we are continuing to innovate in paying for services under fee for service, particularly in the area of post-acute and chronic care; we are experimenting with more flexible purchasing approaches, including competitive bidding and bundled payments; and we are seeking additional legislative authority to be able to purchase services in response to local market conditions. The "Beneficiary-Centered Purchasing Initiative" applies lessons learned from the private sector and HCFA's demonstrations to develop legislative proposals for innovative purchasing arrangements to control Medicare spending now and in the future.

HEALTH DATA

HCFA is the largest consumer and maintainer of health data in the world. There are a number of major initiatives underway to move HCFA into the twenty-first century. The implementation of improved computer systems is one of the biggest internal challenges facing HCFA. We are working to build a new information platform to serve as the foundation of an information management strategy that will improve service to beneficiaries and providers; better manage program expenditures; upgrade our tools for combating fraud and abuse; and deal with new health care delivery options for Medicare beneficiaries.

A second challenge is the Minimum Data Set for nursing homes and a data set called OASIS for home health agencies, which will provide data to enable HCFA to monitor quality, and to plan care for beneficiaries across facilities, and move toward prospective payment in these service areas.

A third challenge is the implementation of the Health Care Portability and Accountability Act, which gives HHS a mandate to move toward the adoption of health data standards for electronic health care commerce. This mandate represents a quantum leap in health data management and will provide greater opportunities for analysis and policy-making at local and national levels.

FRAUD

As we enter the twenty-first century, HCFA is actively transforming its computer technology to keep pace with the many rapid changes occurring in the health care field. The implementation of information technology is essential in combating and preventing fraud and abuse. The consolidation of payment systems will greatly improve our ability to "profile" data on a national or regional basis by type of provider or type of service. We will use these profiles to identify aberrant patterns for review. We are also forging new partnerships to increase cooperation among the federal agencies, state entities, and private industry, to protect the Medicare and Medicaid programs from fraud, abuse, and waste.

We have proposed legislation requiring each health care provider applying for participation in Medicare or Medicaid to provide their social security number and employer identification number. These numbers would allow HCFA to check on an applicant's history for fraudulent activity. Other provisions would target providers who pay kickbacks to encourage referrals and those who declare bankruptcy fraudulently to avoid paying administrative penalties. The substantive claims testing portion of the financial statement audit identified an unacceptable error rate. Some portion of this error rate is caused by fraudulent claims.

BENEFICIARY CHOICE

Beneficiaries should have a wide range of choices to meet their health care needs, whether through managed care or fee-for-service care. Under the Medicare choices initiative, we would expand managed care options, provide beneficiaries with comparative information on all of their health care choices, ease comparison among options by increasing standardization of benefits, provide a coordinated open enrollment period and other enrollment opportunities, and institute Medigap reforms. We want to give beneficiaries the opportunity to take advantage of expanded choice by instituting an annual open enrollment process, similar to that used by the Federal Employees Health Benefits Plan.

We are seeking statutory authority to build on our experience with the Choices demonstration project and contract with Preferred Provider organizations, Provider Sponsored Networks, and other alternative delivery systems that meet strong consumer protection standards.

Beneficiary choice also requires making more and better information available to beneficiaries in a more timely way. It involves stimulating development in the private sector of different models of care and options within the program that reflect what beneficiaries need and want. Under the general rubric of "HCFA-Online," we are developing a range of communication techniques from the most technologically advanced Internet messages to a revised set of hard copy publications in multiple languages. We are also engaged for the first time in systematic and continuing market research to better understand what information beneficiaries want, and how they like to receive it.

BENEFICIARY PROTECTIONS

As we strive to expand beneficiary choice, we have taken steps to protect Medicare managed care enrollees. We have implemented the Anti-gag Rule policy to assure that beneficiaries have information about all the health care options appropriate for them; implemented the Physician Incentive regulation so that financial arrangements between physicians and health plans will be disclosed; taken the lead in setting quality standards for managed care through the implementation of HEDIS® for Medicaid and Medicare and through our partnership with the Foundation for Accountability, to name a few. We are also planning to expedite the managed care grievances and appeals process. We also need to expand the new health insurance portability rules to improve access to Medigap insurance plans, and make it possible for beneficiaries to try managed care and return to fee-for-service and Medigap coverage if they decide to do so.

Overview

Financial Statement Highlights

Chapter 5

Financial Statement Highlights

ASSETS

HCFA's balance sheet has more than $175 billion in assets, concentrated in Investments ($153 billion or 87% of total assets) of the Medicare Trust Funds. These trust funds are U.S. Treasury Special Issues; special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in "interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States."

The next largest asset is the Fund Balance of $15.9 billion (9% of total assets) which is categorized into obligated ($6.8 billion) and unobligated ($9 billion, most of which is restricted and pertains to the Payments to the Health Care Trust Funds appropriation).

Total net accounts receivable is $3.3 billion, (1.9% of total assets). Most overpayments are offset from payments due providers on an ongoing basis throughout the year. The accounts receivable balance represents outstanding overpayments as of September 30, 1996. Included in this balance are amounts for claims in which Medicare should be the secondary rather than the primary payer and amounts under dispute.

LIABILITIES

Liabilities increased from $36.7 billion in 1995 to $50.5 billion in 1996 primarily due to increases in Medicare Payables. Payables represent the dollar value of services rendered but not yet billed, or services billed but not yet reported, in both the Medicare and Medicaid programs. We are looking closely at the estimating method for Medicare Payables which is currently a byproduct of the trust fund projections, and extremely volatile in the short term.

NET POSITION

The Cumulative Results of Operations represent the trust fund investments, reduced by the accrued Medicare and Medicaid benefits payable. The FY 1996 Total Net Position of $125 billion is lower than it was in FY 1995 primarily due to the increase in Medicare payables. The negative balance of $5.6 billion in the Medicaid program occurred because of

the liability reported for Medicaid services incurred but not reported. The lag between services and payment is a normal situation in health insurance programs, and most of these services will be billed and paid in FY 1997.

REVENUE AND FINANCING SOURCES

Revenues for the HI Trust Fund which come primarily through Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) were $106.9 billion in 1996. Income from interest was $10.2 billion, and all other income was $6.1 billion.

The SMI program is financed primarily by a general fund appropriation (Payments to the Health Care Trust Funds) which provided $61.7 billion in 1996, and by monthly premiums paid by beneficiaries. The 1996 SMI premium, set by statute, was $42.50 per month and accounted for $18.9 billion. Interest yielded $1.6 billion.

The total Medicare trust fund income of $205.4 billion in FY 1996, was a 19.2 percent increase over FY 1995. HI Trust Fund income was $123.2 billion, 7.8 percent more than in FY 1995. SMI income increased 41.7 percent to $82.2 billion.

Medicaid is financed by a general fund appropriation provided by Congress. In 1996, the appropriation totaled $82.1 billion.

EXPENSES

Total Medicare expenditures including benefit payments, Peer Review Organization spending, and administrative costs, totaled $211.4 billion, an increase of 21.2 percent over FY 1995. HI Trust Fund expenditures were $142.9 billion in FY 1996, 28.9 percent more than in FY 1995. SMI expenditures rose 7.8 percent to $68.4 billion.

The Medicare Benefit Payments line includes estimated improper payments of $17.8 to $28.6 billion. This represents the results of a sample by the Office of the Inspector General of Medicare claim payments that found less than a one percent error in two categories: (1) whether Medicare benefit payments were made for services which were furnished by certified Medicare providers to eligible beneficiaries, and (2) whether claims were paid by Medicare contractors in accordance with prescribed Medicare laws and regulation. However, in the third area tested, whether the services billed were medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records, an error rate of 10 to 17 percent was found.

Medicare, like other insurers, makes payments based on a standard claims form. Providers are supposed to retain supporting documentation and make it available upon request. Our review of the audit shows that a significant portion of the errors can be attributed to lack of or inadequate documentation on the part of providers who claimed payment. It should be noted that the Medicare benefit payment error rate is not a measurement of fraud and abuse, although some of the errors are undoubtedly due to fraud and abuse.

The HI and SMI Trust Fund income to expense ratios were a mixed picture in FY 1996. The HI Trust Fund took in 87 cents for each dollar expended. The SMI Trust Fund took in $1.21 for each dollar expended, despite the fact that the 1995 SMI premium of $46.10 was reduced to $42.50 in 1996. One of the most important aspects of a financial analysis related to HCFA is the recognition of the issue of long term solvency of the HI Trust Fund (Medicare Part A), which is discussed in the Challenges section. Based on assumptions about demographics, employment, and tax rates, actuarial estimates predict that the fund will become insolvent in the year 2001.

Medicaid expenses were $91.5 billion. This represents grant awards prepared by HCFA's Medicaid Bureau to the States to cover expenses.

HCFA's expenses in FY 1996 include the Quinquennial Adjustment for Military Service Credits of $2.37 billion, which represents noncontributory wage credits of $160 for each month that a military serviceman was active in the military before 1957. Beginning in 1983, the statute requires that a review should be conducted every five years of the amount transferred from the general fund to the HI fund to finance the additional cost incurred by paying benefits which are based on periods of military service for which no contributions were made, or to adjust for changes in the amounts previously transferred for such benefits. The large size of this adjustment is due to a major re-estimate by the Social Security Administration's Office of the Actuary in the number of beneficiaries who are insured solely due to these wage credits. The use of these military service credits will continue to diminish as the years prior to 1957 are used less and less often for those individuals currently applying for Social Security and Medicare benefits.

Overview

Discussion of Auditors' Opinion

Chapter 6

Discussion of Auditors' Opinion

We have worked closely with the auditors to assist them in understanding our very complex programs and processes and the underlying financial systems used to develop this financial statement. We have been hampered in the development of the financial statement because we do not have an integrated accounting system.

The Medicare and Medicaid programs are operated decentrally in a partnership with contractors and States and Territories. This arrangement provides HCFA with operating challenges that are unique within the Federal Government. Unlike Social Security, where 34 million people receive a check every month generated from a central computer system, Medicare and Medicaid are paid by 75 contractors and 57 States and Territories, using multiple systems and processes, that compound the difficulty, complexity, and expense of making systems and operating changes. The systems that have been designed to pay the medical providers and suppliers are segmented according to the type of medical service and the locality where it was provided. From the inception of the program, each contractor and State were allowed to have their own payment process. Over the last few years we have begun standardizing the claims processing systems and standardized interface requirements but each contractor continues to have their own method of operation.

The Medicare program is complex, because we serve beneficiaries, but pay providers. The relationship between the two is difficult to capture through the systems in a way that the cost can be tracked by beneficiary all the way through the system. For example, when a cost is incurred because a beneficiary receives a medical service, the payment is made to the medical provider. A doctor may bill Medicare biweekly for a group of beneficiaries and receive one check. Statistical data is kept by beneficiary, but payment data may not easily reveal which beneficiaries are included when the payments are made. If an overpayment to a provider is inadvertently made one month, it is withheld from the provider check the following month. Although program audits find that our systems are doing the job for which they were intended, i.e., ensuring eligibility of beneficiaries and providers, pricing out medical procedures, paying bills as submitted properly, and making adjustment to provider accounts, the systems do not meet CFO Act and Federal Financial Management Improvement Act requirements for an integrated accounting system.

The ultimate solution to the financial reporting problem at the Medicare contractors is standardization of the reporting process and shared systems, continuously improving

oversight of contractor operations, and automation of the reporting process. We are currently analyzing the shared systems to determine how accounting and reporting processes can be incorporated into their design.

The Medicaid process is complicated by the federal-state relationship. We must ask each State to provide relevant financial reporting that can be incorporated into HCFA's financial statement. States that receive federal funds are subject to a single federal audit. We are working with the State auditors to obtain the necessary data while minimizing the burden on the States.

Corrective Actions

In FY 1997 we will continue to work closely with the auditors, and concentrate our corrective actions on enabling them to assure that three numbers are fairly represented. The three issues and their 1996 values are: Medicare Payables - $36.1 billion, SMI Premiums - $18.9 billion in beneficiary-paid premiums (of which the Social Security Administration collects approximately $16 billion), and the resulting Federal premium contribution of $61.7 billion, and Medicare Receivables - $2.7 billion. During FY 1997, we plan to do the following:

(1) HCFA actuaries, working with the auditors, will attempt to develop an improved methodology for estimating Medicare payables and a procedure for validating estimates. It is hoped that the new process will be in place in time for use in the FY 1997 financial statement.

(2) HCFA will fund an audit of the Social Security Administration's SMI premium collection function. Once audited, the Federal premium contribution can also be validated.

(3) We will focus on improving internal controls on documentation and reconciliation of financial reporting and receivables.

During the following 2 years, we will take steps to implement an integrated accounting system that should correct financial reporting problems and work with the auditors to develop a program to make cost settlement reports more accessible to audit.

Also as part of the audit, OIG has calculated an error rate that measures whether Medicare benefit payments were made correctly. The error rate projected between $17.8 and $28.6 billion in Medicare payments were improper. Medicare, like other insurers, makes

payments based on a standard claims form. Providers are supposed to retain supporting documentation and make it available upon request. Our preliminary review of the audit shows that a significant portion of the errors can be attributed to lack of or inadequate documentation on the part of providers who claimed payment. A detailed corrective action plan is being developed and we will work closely with our provider community to address these problems.

Limitations of the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of HCFA, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990, (P.L. 101-576).

These financial statements have been prepared from HCFA's general ledger and subsidiary reports and supplemented with financial data prepared by the U.S. Treasury in accordance with the formats prescribed by the Office of Management and Budget. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the Budget of the U.S. Government and the annual reports of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

The financial statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity, that liabilities not covered by budgetary resources cannot be liquidated without the enactment of an appropriation, and that payment of all liabilities other than for contracts can be abrogated by the sovereign entity.

Principal Statements

FY 1996 and FY 1995

COMBINED STATEMENTS OF FINANCIAL POSITION
AS OF SEPTEMBER 30, 1996 AND 1995 (Dollars in Millions)

	FY 1996	FY 1995 Restated
ASSETS		
Entity Assets:		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$15,906	$25,370
Investments *(Note 4)*	152,980	143,378
Accounts Receivable, Net *(Note 3)*	4	3
Interest Receivable	2,899	2,885
Governmental Assets:		
Accounts Receivable, Net *(Note 3)*	3,097	2,739
Advances and Prepayments	608	1,642
Restricted Cash	59	
Property and Equipment, Net	49	55
Total Entity Assets	175,602	176,072
Non-Entity Assets:		
Governmental Assets:		
Accounts Receivable, Net *(Note 3)*	265	123
Total Non-Entity Assets	265	123
TOTAL ASSETS	**$175,867**	**$176,195**
LIABILITIES		
Liabilities Covered by Budgetary Resources:		
Intragovernmental Liabilities:		
Accounts Payable *(Note 5)*	$16	$18
Liabilities for Loan Guarantees	6	9
Uncollected Revenue due Treasury *(Note 6)*	265	123
Governmental Liabilities:		
Accounts Payable *(Note 5)*	4	4
Suspense Account Deposit Fund	1	1
Accrued Payroll and Benefits	12	10
Other Governmental Liabilities *(Note 6)*	44,562	36,461
Total Liabilities Covered by Budgetary Resources	44,866	36,626
Liabilities Not Covered by Budgetary Resources:		
Intragovernmental Liabilities:		
Accounts Payable	7	6
Governmental Liabilities:		
Accrued Leave	20	20
Other Governmental Liabilities *(Note 6)*	5,609	
Total Liabilities Not Covered by Budgetary Resources	5,636	26
TOTAL LIABILITIES	**$50,502**	**$36,652**
NET POSITION *(Note 7)*		
Balances:		
Unexpended Appropriations	$9,074	$11,705
Invested Capital	49	55
Cumulative Results of Operations	121,878	127,809
Future Funding Requirements	(5,636)	(26)
TOTAL NET POSITION	**$125,365**	**$139,543**
TOTAL LIABILITIES & NET POSITION	**$175,867**	**$176,195**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF OPERATIONS AND CHANGES IN NET POSITION FOR THE PERIOD ENDING SEPTEMBER 30, 1996 AND 1995

(Dollars in Millions)

	FY 1996	FY 1995 Restated
REVENUE AND FINANCING SOURCES		(Unaudited)
Direct Appropriations Expended	$85,826	$89,250
Employment Tax Revenue *(Note 8)*	106,943	98,054
SMI Premiums *(Note 9)*	18,931	19,243
Federal Matching Contributions *(Note 9)*	61,702	36,988
Revenue From Sales of Goods/Services		
CLIA User Fees	31	28
To The Public	1	1
Intragovernmental	3	4
Interest & Penalties (Non-Fed)	1	1
Interest (Fed)	11,791	12,583
Other Revenue and Financing Sources *(Note 10)*	6,176	5,932
Trust Fund Draws *(Note 10)*	2,096	2,109
Revenue Transferred to Program Management	(2,096)	(2,109)
Collections For Principal Repayments Transferred To The Federal Financing Bank	(3)	(18)
Total Revenues and Financing Sources	**291,402**	**262,066**
EXPENSES		
Program or Operating Expenses		
Medicare Benefit Payments *(Note 11)* *(Includes estimated improper payments of $17.8-$28.6 billion). (Note 12)*	205,835	171,048
Medicaid Benefit Payments *(Note 11)*	91,435	89,235
Administrative Expenses *(Notes 11 and 13)*	3,175	3,226
Depreciation and Amortization *(Note 11)*	5	5
Bad Debts and Writeoffs *(Note 11)*	121	284
Quinquennial Military Service Credit Adjustment	2,366	
Other Expenses	5	3
Total Expenses	**302,942**	**263,801**
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	**(11,540)**	**(1,735)**
Net Position, Beginning Balance	151,057	152,900
Plus (Minus) Prior Period Adjustment *(Note 14)*	(11,514)	(8,889)
Net Position, Beginning Balance as Restated	139,543	144,011
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	(11,540)	(1,735)
Plus (Minus) Non-Operating Changes *(Note 15)*	(2,638)	(2,733)
Net Position, Ending Balance	**$125,365**	**$139,543**

The accompanying notes are an integral part of these statements.

Note 1: Summary of Significant Accounting Policies

Reporting Entity

The Health Care Financing Administration (HCFA) is considered a separate reporting entity of the Department of Health and Human Services (DHHS) for financial reporting purposes. These financial statements have been prepared to report the financial position and results of operations of HCFA, as required by the Chief Financial Officers Act of 1990. The statements were prepared from HCFA's accounting records in accordance with the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 94-01. In addition, these financial statements satisfy certain OMB 97-01 provisions in effect for fiscal year (FY) 1996. OMB 97-01 will be in effect in its entirety for the fiscal year ending September 30, 1998.

These financial statements include the accounts of all funds administered by HCFA, which are discussed below:

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services are charged to the HI Trust Fund. The financial statements include HI Trust Fund activities administered by the U.S. Department of the Treasury.

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by HCFA to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, chronic renal disease, rural health clinic, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services are charged to the SMI Trust Fund. The financial statements include SMI Trust Fund activities administered by the U.S. Department of the Treasury.

Medicaid

Medicaid, the health care program for low-income Americans, is administered by HCFA in partnership with the States through the form of Federal grants. Grant awards prepared by

HCFA's Medicaid Bureau limit the advances that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of HCFA's share of States' Medicaid costs. At the end of each quarter, States submit a report of their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by HCFA for the difference between approved expenses reported for the period and the grant awards previously issued. The financial statements include the approved expenses reported by the States for FY 1996.

Program Management

The Program Management appropriation provides HCFA with the funds to administer and oversee the Medicare and Medicaid programs. The funds for this activity are provided primarily by transfers from the HI and SMI Trust Funds (see Note 10). In addition, user fees collected from Health Maintenance Organizations (HMO) seeking Federal qualification and funds received from other Federal agencies to reimburse HCFA for services performed for them are credited to this appropriation. The Payments to the Health Care Trust Funds appropriation pays the Medicare HI Trust Fund to cover the Medicaid program's share of HCFA's administrative costs (see Note 10). HCFA's cost allocation system determines the distribution of funds between the funding sources. All expenses charged to the Program Management appropriation, except HMO user fees and reimbursements from other agencies, are allocated to the Medicare HI and SMI and the Medicaid programs, and are reported to those programs in the Supplemental Information section of this report. HMO user fees and the reimbursements from other Federal agencies are shown in the "All Others" column.

The following accounts are reported in the "All Others" column of the financial statements by activity.

Payments to the Health Care Trust Funds

The Social Security Act provides for payments to the HI and SMI Trust Funds for Supplementary Medical Insurance (appropriated funds to provide for federal matching of SMI premium collections), Hospital Insurance for the Uninsured, and Federal Uninsured Payments. In addition, funds are provided by this appropriation to cover the Medicaid program's share of HCFA's administrative costs charged to the Program Management appropriation. For purposes of financial statement presentation, the revenue and expenses of this appropriation are reported only in the Medicare HI and SMI accounts.

A transfer of general funds to the HI Trust Fund in an amount equal to Self-Employment Contribution Act (SECA) tax credits is also made through the Payments to the Health Care Trust Funds appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 1996 are adjustments for late or amended tax returns. For purposes of financial statement presentation, the revenue and expenses for this account are reported only in the Medicare HI accounts.

Suspense Account

Agencies are required to deposit receipts expeditiously. Unidentified collections are deposited into a suspense account for immediate availability to Treasury while HCFA researches the actual application of funds.

Miscellaneous Fines, Penalties, and Forfeitures

Civil monetary penalties and Freedom of Information administrative fees are assessed on overdue payments.

Interest Receipts

Interest collections from overdue debts are deposited to miscellaneous receipt accounts managed by the Department of the Treasury.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs.

The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, HCFA collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

Clinical Laboratory Improvement Amendments (CLIA)

The Clinical Laboratory Improvement Amendments of 1988 marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. HCFA and the Public Health Service share responsibility for the CLIA program, with HCFA having the lead responsibility for financial management.

Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Proceeds from the sale of publications under the Freedom of Information Act are also credited to this fund. Therefore, like the HMO program, the CLIA fund operates as a revolving fund.

Program Management

Activities related to HMO user fee collections and reimbursements to HCFA from other Federal agencies that are charged to the Program Management appropriation are reported in the "All Others" column of the Combined Financial Statements by Activity. The balance of the Program Management appropriation data is cost allocated among the HI and SMI Trust Funds and Medicaid and is reported to those programs in the Supplemental Information section of the Financial Report.

Income Tax on Old Age and Survivors and Disability Insurance (OASDI)

The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of OASDI benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent for taxable years beginning in 1994. The revenues resulting from this increase are transferred to the HI Trust Fund.

For purposes of financial statement presentation, the revenue and expenses for this account are reported only in the Medicare HI accounts.

Basis of Accounting

Transactions are recorded using both the accrual and cash bases of accounting and a budgetary basis. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed.

HCFA uses the cash basis of accounting in the Medicare Program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmaked for the Medicare program are recorded on a cash basis.

HCFA uses the cash method in the Medicaid Program to record draws by the States to cover current quarter expenses, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to HCFA as of the fiscal year end. Revenues are recognized as appropriated capital is used.

Budgetary accounting facilitates compliance with legal constraints and controls over the use of Federal funds. HCFA uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by the U.S. Department of Health and Human Services.

Funds with the U.S. Treasury and Cash

Cash receipts and disbursements are processed by the U.S. Treasury. Funds with Treasury are primarily available to pay current liabilities. HCFA also maintains lockboxes at commercial banks for the deposit of SMI premiums from States and third parties and for collections from HMO plans.

The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Contractors issue checks against a Medicare Benefits Account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits Accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

The total amount of HI and SMI time account balances at the contractors' commercial banks is reported as Restricted Cash on the Combined Statements of Financial Position.

Investments

Sections 1817(c) for HI and 1841(c) for SMI of the Social Security Act require that trust fund holdings not necessary to meet current expenditures be invested in "interest bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." These investments are carried at face value as determined by the U.S. Treasury. Interest income is compounded semi-annually (June and December) and has been adjusted to include an accrual for interest earned from July 1 to September 30.

Liabilities

Liabilities represent the amount of monies or other resources that are likely to be paid by HCFA as the result of a transaction that has occurred. However, no liability can be paid by HCFA without an appropriation. Liabilities for which an appropriation have not been enacted are classified as unfunded liabilities. In FY 1996, for the first time, HCFA is showing a Medicaid payable amount that represents Medicaid claims that have been incurred by States as of September 30 but have not yet been reported to HCFA. These claims will be reported to, and paid by, HCFA in FY 1997 and therefore, are shown as unfunded liabilities in FY 1996.

Retirement Plan

HCFA employees participate in the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, HCFA makes matching contributions equal to seven percent of pay. HCFA does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of the Office of Personnel Management and the Federal Employees Retirement System.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which HCFA is required to contribute one percent of pay and to match employee contributions up to an additional four percent of pay. For employees covered by FERS, HCFA also contributes the employer's matching share of Social Security taxes.

Estimation of Obligations Related to Cancelled Appropriations

As of September 30, 1996, HCFA has cancelled over $76 million in cumulative obligations to FYs 1991 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991, (P.L.101-150). Based on the payments made in FYs 1992 through 1996 related to cancelled appropriations, HCFA anticipates an additional $4.7 million will be paid from current year funds for cancelled obligations.

Accounting Changes

The following modifications to the reporting of expenses and net position affect the comparative financial statements for FYs 1996 and 1995:

1) Administrative Expenses

Prior to FY 1996, the transfer of Railroad Retirement principal from the Social Security Equivalent Benefit Account (formerly the Railroad Retirement Account) to the HI Trust Fund was reported as a reduction to administrative expenses and not as revenue. For FY 1996, Railroad Retirement principal has been reported as revenue (see Note 10). The FY 1995 Combined Statement of Operations has been restated to reflect this reclassification.

2) Bad Debt Expenses

In FY 1995, HCFA reported, for the first time, bad debt expenses for trust fund accounts receivable deemed to be uncollectible. The bad debt expense covered FYs 1990-1995. Initial allowances totaling $1.7 billion were established for HI and SMI uncollectible accounts receivable, with $1.7 billion also reported as bad debt expenses. Of the total bad debt expenses, $284 million represent bad debt expenses charged against FY 1995 (as restated in the comparative Combined Statement of Financial Position) and $1,450 million apply to FY 1994 and prior years (as restated in FY 1995 Prior Period Adjustments). The FY 1996 bad debt expense of $121 million represents the net increase recorded for the current fiscal year in the HI and SMI allowances for uncollectible accounts.

3) FY 1995 HMO Payments

HCFA issued payments of $1.3 billion to HMO plans on September 29, 1995. HCFA originally reported these payments as FY 1995 expenses. The expenses should have been charged to FY 1996 because they were payments due HMOs in October 1995 (FY 1996). FY 1995 expenses and net position have been restated in the Combined Statements of Financial Position and the Combined Statements of Operations and Changes in Net Position. In addition, the change in the FY 1995 Net Position has been reflected in the FY 1996 prior period adjustments. The $1.3 billion October 1995 payments have been included in FY 1996 HI and SMI Medicare benefit payments.

4). Quinquennial Military Service Credit Adjustment

In FY 1996, $2.37 billion was transferred from the HI Trust Fund to the general fund of the Treasury in FY 1996 for costs attributable to noncontributory wage credits for military service performed before January 1, 1957. The Social Security Amendments of 1983 (Section 217(g) of the Social Security Act) require that these costs be recomputed every 5 years. Previous transfers from the general fund to HI occurred in 1985 and 1990. This amount represents the estimated present value of all past and future HI costs attributable to pre-1957 military service wage credits, less the accumulated value of past reimbursements. The large size of this readjustment is due primarily to a major re-estimate by the Social Security Administration's Office of the Actuary in the number of beneficiaries who are insured solely due to these wages. Since Social Security benefits are computed using the highest 35 years and require a maximum of 40 quarters for full coverage, the years from 1951 to 1956 will be used less often in future.

5) Cumulative Results of Operations

Prior to FY 1996 the Cumulative Results of Operations were reported as part of Unexpended Appropriations in the Net Position section of the Statement of Financial Position. For FY 1996 and 1995, the Cumulative Results of Operations are shown separately.

Note 2: Fund Balances (Dollars in Millions)

Entity Fund Balances: 1996	Obligated	Unobligated Available	Unobligated Restricted	Total
Trust Funds.....				
HI Trust Fund Balance	$(460)			$(460)
SMI Trust Fund Balance	(206)			(206)
Revolving Funds.....				
HMO Loan *(1)*		$10		10
CLIA *(1)*	7	18		25
Appropriated Funds.....				
Medicaid *(2)*	7,500			7,500
Payments to the Health Care Trust Funds *(1)*			$9,036	9,036
Other Fund Types.....				
HCFA Suspense Account *(1)*		1		1
Total Entity Fund Balances	**$6,841**	**$29**	**$9,036**	**$15,906**

(1) These fund balances are reported in the Supplemental Information section under "All Others" on the Statement of Financial Position by Activity.

(2) The Medicaid fund balance decreased by $9.85 billion, the amount by which Medicaid outlays exceeded the Medicaid appropriation received in FY 1996. In determining its Medicaid funding requirements for FY 1996, HCFA had reduced its overall FY 1996 appropriation request by the $12.74 billion in available unobligated funds carried forward from FY 1995.

Entity Fund Balances: 1995	Obligated	Unobligated Available	Unobligated Restricted	Total
Trust Funds.....				
HI Trust Fund Balance	$(349)			$(349)
SMI Trust Fund Balance	351			351
Revolving Funds.....				
HMO Loan *(1)*	1	$10		11
CLIA *(1)*	7	15		22
Appropriated Funds.....				
Medicaid *(2)*	4,606	12,740		17,346
Payments to the Health Care Trust Funds *(1)*			$7,988	7,988
Other Fund Types.....				
HCFA Suspense Account *(1)*		1		1
Total Entity Fund Balances	**$4,616**	**$12,766**	**$7,988**	**$25,370**

Note 3: Accounts Receivable, Net (Dollars in Millions)

1996	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Entity/Intragovernmental						
Accounts Receivable	$1	$3	$4			$4
Less: Allowance for Uncollectible Accounts						
Net Entity Intragovernmental A/R	**$1**	**$3**	**$4**			**$4**
Entity/Governmental						
Accounts Receivable	$3,115	$1,831	$4,946	$41	$6	$4,993
Less: Allowance for Uncollectible Accounts	1,134	762	1,896			1,896
Net Entity Governmental A/R	**$1,981**	**$1,069**	**$3,050**	**$41**	**$6**	**$3,097**
Non-Entity/Governmental						
Accounts Receivable					$484	$484
Less: Allowance for Uncollectible Accounts					219	219
Net Non-Entity Governmental A/R					**$265**	**$265**

The accounts receivable were primarily obtained from data provided by the Medicare contractors. The majority of these receivables are contractor overpayments to providers, beneficiaries, physicians and suppliers, and those claims in which Medicare should be the secondary rather than the primary payer (Medicare Secondary Payer-MSP-claims). Only those MSP claims that have been identified to a debtor, and for which a collectible amount has been determined, are included in the accounts receivable. An additional 1.4 million claims are being researched as potential MSP accounts receivable and have not been reported due to the uncertain nature of the leads.

The majority of the allowance for uncollectible accounts derives from Medicare contractor data based on the last 5 years (if available) of historical loss experience by type. The allowance has been adjusted for those contractors that did not report historical loss experience. The balance of the allowance was reported by HCFA components as a result of an analysis of individual debtors and a group analysis that included accounts receivable that were outstanding for more than 1-year that did not have payment activity within that year. No allowance for doubtful accounts is shown for the Medicaid accounts receivable. The Medicaid accounts receivable has been recorded at net realizable value, based on an historic analysis of actual State recoveries. The Medicaid accounts receivable,

	Medicare		Total		All	Combined
1995 (Restated)	**HI**	**SMI**	**Medicare**	**Medicaid**	**Others**	**Total**
Entity/Intragovernmental						
Accounts Receivable	$1	$2	$3			$3
Less: Allowance for Uncollectible Accounts						
Net Entity Intragovernmental A/R	**$1**	**$2**	**$3**			**$3**
Entity/Governmental						
Accounts Receivable	$2,596	$1,844	$4,440	$93	$10	$4,543
Less: Allowance for Uncollectible Accounts	1,044	760	1,804			1,804
Net Entity Governmental A/R	**$1,552**	**$1,084**	**$2,636**	**$93**	**$10**	**$2,739**
Non-Entity/Governmental						
Accounts Receivable					$375	$375
Less: Allowance for Uncollectible Accounts					252	252
Net Non-Entity Governmental A/R					**$123**	**$123**

$41 million, represent those expenses incurred by the States that have been disallowed by HCFA; of this amount, $33 million are under review by the DHHS Appeals Board.

Note 4. Investments and Interest Receivable (Dollars in Millions)

1996	Maturity Range	Interest Range	Value
HI			
Certificates	June 1997	6 7/8 - 7 1/8%	$2,852
Bonds	June 1997 to June 2011	6 1/4 - 13 3/4%	122,953
Total HI Investments			**125,805**
SMI			
Certificates	June 1997	6 7/8 - 7 1/8%	3,949
Bonds	June 1998 to June 2011	6 1/4 - 13 3/4%	23,226
Total SMI Investments			**27,175**
Total Medicare Trust Fund Investments			**$152,980**

U.S. Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust funds. Special issues are always purchased and redeemed at face value. The face value less amounts retired to fund Medicare program expenses by the programs is the net amount outstanding reported in the Combined Statement of Financial Position. This schedule summarizes the nature and amount of investments in the Medicare trust funds. See Statement of Accounts for HI and SMI Trust Fund Investments in the Supplemental Information section for a detailed description of the holdings.

1995	Maturity Range	Interest Range	Value
HI			
Certificates	June 1996	6 1/2 - 6 5/8%	$262
Bonds	June 1996 to June 2010	6 1/4 - 13 3/4%	129,602
Total HI Investments			**129,864**
SMI			
Certificates	June 1996	6 1/2 - 6 5/8%	
Bonds	June 1996 to June 2009	6 1/4 - 13 3/4%	13,514
Total SMI Investments			**13,514**
Total Medicare Trust Fund Investments			**$143,378**

Interest Receivable

The Interest receivable is reported to HCFA by the U.S. Treasury and reflects the interest due the trust funds as of September 30, 1996 and 1995 from the investments listed above.

Note 5. Accounts Payable (Dollars in Millions)

INTRAGOVERNMENTAL

Total intragovernmental accounts payable of $16 million ($18 million in FY 1995) include:

* $15 million ($16 million in FY 1995) due the U.S. Treasury for the uncollected portion of Trust Fund Miscellaneous Receipts; and

* $1 million ($2 million in FY 1995) accrual of HCFA postal and rental expenses due the U.S. Post Office and General Services Administration, respectively.

GOVERNMENTAL

* $4 million ($4 million in FY 1995) accrual for Program Management rent, utility and miscellaneous charges.

Note 6. Other Liabilities (Dollars in Millions)

1996	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Other Liabilities Covered by Budgetary Resources						
Intragovernmental:						
Uncollected Revenue due Treasury					$265	**$265**
Total Other Intragovernmental Liabilities					**$265**	**$265**
Governmental:						
Medicare Benefits Payable *(1)*	$33,574	$2,472	$36,046			36,046
Premiums Billed/Not Yet Due & Unearned Advances *(2)*	103	248	351			351
Demonstration Projects and HMO Benefits	25	4	29			29
Medicaid Benefits Incurred/Not Yet Billed *(3)*				$7,715		7,715
Medicaid Audit/Program Disallowances *(4)*				421		421
Total Other Governmental Liabilities Covered by Budgetary Resources	**$33,702**	**$2,724**	**$36,426**	**$8,136**		**$44,562**
Other Liabilities Not Covered by Budgetary Resources *(5)*						
Governmental:						
Medicaid Benefits Incurred/Not Yet Billed *(3)*				$5,609		$5,609
Total Other Liabilities Not Covered by Budgetary Resources				**$5,609**		**$5,609**

(1) The Medicare benefits payable of $36,046 million ($21,981 million in FY 1995) is the estimate by the Office of the Actuary of Medicare services incurred but not paid as of September 30, 1996. The estimates are based on historical trends of completeness that take into consideration estimated deductible and coinsurance amounts. The estimates represent (a) claims that have been submitted to the Medicare contractors that have not yet been approved for payment, (b) claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim that have not yet been cashed by payees, and (d) the costs of services rendered as of September 30 but not yet billed. The payable estimate is a by-product of the actuarial estimates that are included in the HI and SMI Annual Reports of the Boards of Trustees (whose methodology is also employed in all annual budget exercises including the President's Budget and Mid-Session Review and in the annual development of the SMI premium). The actuarial estimated accounts payable is a volatile amount due to the health care environment and slight differences in the accumulated incurred benefits and accumulated cash benefits can cause substantial changes in the estimated amount.

(2) Governmental liabilities covered by budgetary resources of $351 million ($351 million in 1995) consist of (a) Medicare premiums billed (included in the FY 1996 accounts receivable reported) prior to September 30, 1996, but due in the following reporting period and (b) premiums that were received but unbilled.

(3) The Medicaid benefits incurred not yet billed amount of $13,324 million, ($13,760 million in FY 1995 restated) comprises:

$11,082 million, which is the net Federal share of expenses that have been incurred by the States but not yet reported to HCFA as of September 30, 1996. The amount reported is the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. This information was provided by the States in response to a survey issued by HCFA in November 1996.

$2,242 million, which is the Federal share of expenses due the States that have exceeded advances drawn by the States.

Of the $13,324 million total liability, $7,715 million is covered by Medicaid appropriation authority that was available as of September 30, 1996, and it is anticipated that the remaining $5,609 million will be funded by the FY 1997 Medicaid appropriation.

(4) Medicaid audit and program disallowances of $421 million ($317 million, in FY 1995) are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to HCFA. HCFA will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. HCFA defers the payment of these claims until the State provides additional supporting data. Based on historical data, HCFA expects to eventually pay about 25.8 percent of total contingent liabilities. Therefore, of the total contingent liabilities of $1,634 million, HCFA expects to pay approximately $421 million.

(5) Other liabilities do not include all provider cost reports under appeal at the Office of Hearings (OH). The monetary effect of those appeals is generally not known until a decision is rendered.

As of September 30, 1996, there were 9,821 cases in appeal at the OH. A total of 2,643 of these cases were filed in FY 1996. The OH rendered decisions on 75 cases in FY 1996 while 2,016 additional cases were dismissed, withdrawn or settled prior to an appeal hearing. OH gets no information on the value of these cases that are settled prior to a hearing. In addition, a reasonable liability estimate cannot be projected for the value of the 9,821 cases remaining in appeal as of September 30 from the data available for the 75 cases that were decided in FY 1996. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

1995 (Restated)	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Other Liabilities Covered by Budgetary Resources						
Intragovernmental:						
Uncollected Revenue due Treasury					$123	**$123**
Total Other Intragovernmental Liabilities					**$123**	**$123**
Governmental:						
Medicare Benefits Payable	$18,486	$3,495	$21,981			21,981
Premiums Billed/Not Yet Due and Unearned Advances	92	259	351			351
Demonstration Projects and HMO Benefits	38	14	52			52
Medicaid Benefits Incurred/Not Yet Billed				$13,760		13,760
Medicaid Audit/Program Disallowances				317		317
Total Other Governmental Liabilities Covered by Budgetary Resources	**$18,616**	**$3,768**	**$22,384**	**$14,077**		**$36,461**

Note 7: Net Position (Dollars in Millions)

BY PROGRAM	Medicare		Total		All	Combined
1996	HI	SMI	Medicare	Medicaid	Others	Total
Unexpended Appropriations:						
Unobligated						
Available					$28	$28
Unavailable					9,036	9,036
Undelivered Orders					10	10
Invested Capital	$17	$30	$47	$2		49
Cumulative Results of Operations	96,092	25,786	121,878			121,878
Future Funding Requirements	(8)	(18)	(26)	(5,610)		(5,636) *(1)*
Total	**$96,101**	**$25,798**	**$121,899**	**$(5,608)**	**$9,074**	**$125,365**

BY FUND TYPE	Revolving Funds	Trust Funds	Appropriate Funds	Combined Total
Unexpended Appropriations:				
Unobligated				
Available	$28			$28
Unavailable			$9,036	9,036
Undelivered Orders	10			10
Invested Capital		$47	2	49
Cumulative Results of Operations		121,878		121,878
Future Funding Requirements		(26)	(5,610)	(5,636) *(1)*
Total	**$38**	**$121,899**	**$3,428**	**$125,365**

(1) The Medicaid program has recorded a $5.6 billion future funding requirement. FY 1996 is the first time HCFA has recorded a liability for Medicaid services incurred but not reported as of the end of the fiscal year. This information was provided by the States in response to a survey issued by HCFA in November 1996. The liability ($11.1 billion out of the total $13.7 billion for Medicaid) is an estimate of medical services provided but not yet billed, or billed but not yet paid by the States. The lag between services and payment is a normal situation in a health insurance program, and most of these services will be billed and paid in FY 1997. Without this amount, the Medicaid unexpended appropriation would be $6.3 billion as of September 30, 1996. FY 1995 has been restated to reflect a similar charge in FY 1995.

Future funding will be required to pay the accrual for annual leave that has been allocated to the Medicare trust funds and Medicaid, and for current year Federal Employees' Compensation Benefit expenses.

BY PROGRAM	Medicare		Total		All	Combined
1995 (Restated)	HI	SMI	Medicare	Medicaid	Others	Total
Unexpended Appropriations:						
Unobligated						
Available				$206	$26	$232
Unavailable					7,988	7,988
Undelivered Orders				3,474	11	3,485
Invested Capital	$19	$32	$51	4		55
Cumulative Results of Operations	115,803	12,006	127,809			127,809
Future Funding Requirements	(8)	(17)	(25)	(1)		(26)
Total	**$115,814**	**$12,021**	**$127,835**	**$3,683**	**$8,025**	**$139,543**

BY FUND TYPE	Revolving Funds	Trust Funds	Appropriated Funds	Combined Total
Unexpended Appropriations:				
Unobligated				
Available	$26		$206	$232
Unavailable			7,988	7,988
Undelivered Orders	11		3,474	3,485
Invested Capital		$51	4	55
Cumulative Results of Operations		127,809		127,809
Future Funding Requirements		(25)	(1)	(26)
Total	**$37**	**$127,835**	**$11,671**	**$139,543**

Note 8: Employment Tax Revenue (Dollars in Millions)

In calendar years 1996 and 1995, all employees and employers were each required to contribute 1.45 percent of employees' wages, with no limitation, to the Federal Medicare Hospital Insurance (HI) Trust Fund.

The Social Security Act requires the transfer of these contributions from the General Fund of the U.S. Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration's (SSA) records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 and W-2 and W-3 forms submitted by taxpayers as the basis for conducting an interim certification of regular wages.

Employment tax revenues are adjusted by excess contributions collected that are refunded to employees. In FY 1996, the HI Trust Fund received a recoupment of $17.4 million to adjust excess contributions that had been refunded in prior years.

Note 9: SMI Premiums Collected and Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and matched by the Federal government. The monthly SMI premium for the first 3 months of FY 1996 was $46.10; the monthly premium for the remainder of the fiscal year was $42.50. Premiums collected from beneficiaries totalled $18.9 billion in FY 1996 ($19.2 billion in FY 1995) and were matched by a $54.7 billion contribution from the Federal government ($37 billion in FY 1995). In March 1996, the Federal government contributed an additional $7 billion to SMI to restore a shortfall in matched funds during FY 1995, resulting in a total matching contribution of $61.7 billion during FY 1996. While this amount is included in FY 1996 revenue, we (HCFA and DHHS) are currently working with OMB, GAO, and the OIG to determine the most appropriate accounting and legal treatment. This effort may result in a prior period accounting adjustment. HCFA uses the Payments to the Health Care Trust Funds appropriation to match SMI premiums collected from beneficiaries.

Note 10: Other Revenue and Financing Sources (Dollars in Millions)

1996	Medicare HI	Medicare SMI	Total Medicare	All Others	Combined Total
Premiums-Uninsured Individuals	$1,108		$1,108		$1,108
Transfer-Uninsured Coverage	419		419		419
Program Management Admin. Expense *(1)*	145		145		145
Military Service Contribution	73		73		73
Principal Payments				$3	3
Income Tax Credit Reimbursement-SECA	(10)		(10)		(10)
Income Tax OASDI Benefits	4,069		4,069		4,069
Railroad Retirement Principal	362		362		362
Gifts and Miscellaneous	2	$4	6		6
Interagency Agreements	1		1		1
Total Other Revenue	**$6,169**	**$4**	**$6,173**	**$3**	**$6,176**

(1) During FY 1996, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund $145 million to cover the Medicaid program's share of HCFA's administrative costs.

Funds are obtained from the HI and SMI Trust Funds as cash is needed to pay for Program Management appropriation expenses. During FY 1996, a total of $2,096 million ($2,109 million in FY 1995) was obtained from the trust funds to cover cash outlays. Of this amount, $1,822 million ($1,849 million in FY 1995) was needed to pay for expenses incurred against current year obligations and $274 million ($260 million in FY 1995) was needed for expenses incurred against prior year obligations.

1995 (Restated) (Unaudited)	Medicare HI	Medicare SMI	Total Medicare	All Others	Combined Total
Premiums-Uninsured Individuals	$999		$999		$999
Transfer-Uninsured Coverage	462		462		462
Program Management Admin. Expense	130		130		130
Military Service Contribution	61		61		61
Principal Payments				$6	6
Income Tax Credit Reimbursement	(1)		(1)		(1)
Income Tax OASDI Benefits	3,913		3,913		3,913
Railroad Retirement Principal	358		358		358
Gifts and Miscellaneous	1	$3	4		4
Total Other Revenue	**$5,923**	**$3**	**$5,926**	**$6**	**$5,932**

Note 11: Expenses by Object Class (Dollars in Millions)

1996	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Program Expenses by Object Class:						
Medicare						
Insurance Claims and Indemnities						
Fee for Service	$128,448	$58,248	$186,696			$186,696
Managed Care	10,741	8,398	19,139			19,139
Medicaid						
Grants, Subsidies and Contributions				$91,435		91,435
Total Program Expenses	**$ 139,189**	**$66,646**	**$205,835**	**$91,435**		**$297,270**
Operating Expenses by Object Class:						
Administrative						
Personal Services and Benefits	$593	$552	$1,145	$13	$5	$1,163
Contractual Services	664	1,162	1,826	85	28	1,939
Grants, Subsidies and Contributions	9	22	31	2		33
Travel and Transportation	1	3	4			4
Rental, Communication and Utilities	7	16	23	2		25
Printing and Reproduction	2	3	5			5
Supplies and Materials	1	2	3			3
Equipment	1	2	3			3
Total Administrative Expenses	**$1,278**	**$1,762**	**$3,040**	**$102**	**$33**	**$3,175**
Depreciation and Amortization	$2	$3	$5			**$5**
Bad Debts and Writeoffs	93	28	121			**121**
Quinquennial Military Service Credit Adj.	2,366		2,366			**2,366**
Other Expenses	1	3	4		1	**5**
Total Expenses by Object Class	**$142,929**	**$68,442**	**$211,371**	**$91,537**	**$34**	**$302,942**

1995 (Restated) (Unaudited)	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Program Expenses by Object Class:						
Medicare						
Insurance Claims and Indemnities						
Fee for Service	$102,013	$55,237	$157,250			$157,250
Managed Care	7,417	6,381	13,798			13,798
Medicaid						
Grants, Subsidies and Contributions				$89,235		89,235
Total Program Expenses	**$109,430**	**$61,618**	**$171,048**	**$89,235**		**$260,283**
Operating Expenses by Object Class:						
Administrative						
Personal Services and Benefits	$604	$536	$1,140	$14	$5	$1,159
Contractual Services	678	1,174	1,852	98	33	1,983
Grants, Subsidies and Contributions	15	36	51	3		54
Travel and Transportation	1	2	3			3
Rental, Communication and Utilities	5	12	17	1		18
Printing and Reproduction	1	3	4			4
Supplies and Materials		1	1			1
Equipment	1	3	4			4
Total Administrative Expenses	**$1,305**	**$1,767**	**$3,072**	**$116**	**$38**	**$3,226**
Depreciation and Amortization	$1	$4	$5			$5
Bad Debts and Writeoffs	180	104	284			284
Other Expenses	1	2	3			3
Total Expenses by Object Class	**$110,917**	**$63,495**	**$174,412**	**$89,351**	**$38**	**$263,801**

Note 12: Medicare Claims Estimated Improper Payments

Federal government audits require the review of programs for compliance with Federal laws and regulations. Accordingly, the OIG reviewed a statistically valid sample of Medicare claims to determine that claims were paid properly by Medicare contractors, and that services were actually performed and were medically necessary. Medicare, like other insurers, makes payments based on a standard claims form. The internal claims process involves reviewing claims as billed and paying the correct amount for the services rendered. This process has less than a 1 percent error rate. However, the external billing process, i.e., the documentation provided by providers to support their claims, had a dollar error rate in the range of $17.8-$28.6 billion. Providers are supposed to retain supporting documentation and make it available upon request. The majority of the errors fell into four broad categories: insufficient or no documentation, lack of medical necessity, non-covered or unallowable service, and incorrect coding. The audit was not performed in FY 1995; therefore, the estimated improper payments are not presented for FY 1995.

Note 13. Administrative Expenses (Dollars in Millions)

MEDICARE

	1996	1995 (Unaudited) (Restated)
Hospital Insurance		
U.S. Department of Treasury	$40	$45
Social Security Administration (SSA)	458	476
Health Care Financing Administration	574	589
Office of the Secretary - DHHS	22	9
Payment Assessment Commission	3	4
Policy and Research		3
Peer Review Organizations	181	180
Total HI Administrative Expenses	**$1,278**	**$1,306**
Supplementary Medical Insurance		
U.S. Dept. of Treasury/Office of Personnel Management		$1
Social Security Administration	$354	356
Health Care Financing Administration	1,373	1,380
Office of the Secretary - DHHS	17	7
Payment Assessment Com./SSA Construction	1	1
Physicians Payment Review Commission	3	4
Policy and Research		2
Railroad Retirement Board	5	5
Peer Review Organizations	9	10
Total SMI Administrative Expenses	**$1,762**	**$1,766**
Total Medicare Trust Fund Administrative Expenses	**$3,040**	**$3,072**
Medicaid		
Health Care Financing Administration	**$102**	**$116**
All Others	**33**	**38**
Total Administrative Expenses	**$3,175**	**$3,226**

For purposes of financial statement presentation, administrative costs are considered expensed to the Medicare trust funds when outlayed by the U.S. Treasury even though some funds may have been used to pay for assets such as property and equipment. In this regard, the Social Security Administration (SSA) reported $79.1 million ($77.7 million in FY 1995) of Property and Equipment, (Net) attributable to the Medicare program as of September 30, 1996. This amount is not included in HCFA's Combined Statement of Financial Position as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 1996 to pay for this activity are

included in this section as an administrative expense to the Medicare program. The SSA administrative costs are reported to HCFA by the U.S. Treasury. These expenses are also reported by SSA on their FY 1996 Annual Financial Statement.

HCFA's administrative costs have been allocated to the Medicare and Medicaid programs based on the HCFA cost allocation system. Administrative costs allocated to the Medicare program include $1.5 billion paid to Medicare contractors to carry out their responsibilities as HCFA's agents in the administration of the Medicare program.

Note 14: Prior Period Adjustments (Dollars in Millions)

	Medicare		Total		All	Combined
1996	HI	SMI	Medicare	Medicaid	Others	Total
Adjustment to FY 1995 HI Accounts Receivable *(1)*	$(602)		$(602)			$(602)
Current Year Expenses Charged to FY 1995 *(2)*				$(12,217)		(12,217)
September 1995 HMO Payments *(3)*	725	$580	1,305			1,305
TOTAL PRIOR PERIOD ADJUSTMENTS	**$123**	**$580**	**$703**	**$(12,217)**		**$(11,514)**

(1) Accounts receivable for Medicare contractor HI overpayments were overstated in FY 1995 by $602 million. The amounts reported for accounts receivable and Net Position for FY 1995 have each been reduced by $602 million on the Combined Statement of Financial Position.

(2) Of the ($12,217) million Medicaid adjustment, ($9,564) million is HCFA's estimate of Medicaid services incurred but not reported as of September 30, 1995, based on data provided by the States in the November 1996 HCFA survey. An additional ($2,653) million represents Medicaid expenses applicable to FY 1995 that exceeded advances drawn by the States in FY 1995. The FY 1995 accounts payable and Net Position have been restated on the Combined Statement of Financial Position.

(3) HCFA issued October 1995 (FY 1996) payments of $1.3 billion to HMO plans on September 29, 1995. HCFA originally reported these payments as expenses in FY 1995. The expenses should have been charged to FY 1996. FY 1995 expenses and net position have been restated in the Combined Statements of Financial Position and the Combined Statements of Operartions and Changes in Net Position. The expenses have been included in FY 1996 HI and SMI Medicare benefit payments.

1995 (Restated) (Unaudited)	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Employment Tax Liability for FY 1994 and prior *(1)*	$3,682		$3,682			$3,682
Bad Debt Expense applicable to FY 1994 and prior *(2)*	(851)	$(599)	(1,450)			(1,450)
Expenses applicable to FY 1994 and prior *(3)*				$(11,121)		(11,121)
TOTAL PRIOR PERIOD ADJUSTMENTS	**$2,831**	**$(599)**	**$2,232**	**$(11,121)**		**$(8,889)**

(1) Pursuant to the Comptroller General of the United States Decision, B-261522, September 29, 1995, the Employment Tax Liability of the HI Trust Fund established in FY 1994 has been reversed. This item was originally reported in the 1995 HCFA Financial Report.

(2) As mentioned in "Accounting Changes" (see Note 1), the Medicare HI and SMI bad debt expenses originally reported in FY 1995 have been restated to show bad debt expenses applicable to FY 1995 and to FY 1994 and prior. Of the original $1,734 million combined trust fund expense, $284 million applies to FY 1995 and $1,450 million applies to FY 1994 and prior years.

(3) Of the ($11,121) million Medicaid adjustment, ($9,534) million is HCFA's estimate of Medicaid services incurred but not reported as of September 30, 1994. An additional ($1,587) million represents Medicaid expenses applicable to FY 1994 that exceeded advances drawn by the States in FY 1994.

Note 15. Non-Operating Changes (Dollars in Millions)

1996	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Current Year Warrants Exceeding (Less Than) Appropriated Capital Used *(1)*				$(3,684)	$1,047	$(2,637)
Disposition of Federal Property	$(1)		$(1)			(1)
TOTAL NON-OPERATING CHANGES	**$(1)**		**$(1)**	**$(3,684)**	**$1,047**	**$(2,638)**

(1) The FY 1996 Medicaid Unexpended Appropriation balance decreased by $3,684 million from FY 1995 (see Note 7). The FY 1996 Payments to the Health Care Trust Funds appropriation of $63,313 million exceeded actual total FY 1996 transfers of $62,266 million by $1,047 million.

1995 (Restated) (Unaudited)	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined Total
Payments to the Health Care Trust Funds					$(33)	$(33)
Cancelled Year Funds	$(1)	$(1)	$(2)		(2,715)	(2,717)
Current Year Warrants Exceeding Appropriated Capital Used *(1)*				$5	12	17
TOTAL NON-OPERATING CHANGES	**$(1)**	**$(1)**	**$(2)**	**$5**	**$(2,736)**	**$(2,733)**

(1) The FY 1995 HCFA Financial Report originally reported that the FY 1995 Medicaid appropriation exceeded FY 1995 Medicaid expenses by $1,239 million. The FY 1995 Medicaid expense has been restated at $89,235 million, which is $5 million less than FY 1995 appropriation.

All of the other amounts are unchanged from the FY 1995 Financial Report.

Supplemental Financial and Management Information

COMBINING STATEMENT OF FINANCIAL POSITION BY ACTIVITY
AS OF SEPTEMBER 30, 1996

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
ASSETS						
Entity Assets:						
Intragovernmental Assets:						
Fund Balance with Treasury	$(460)	$(206)	$(666)	$7,500	$9,072	$15,906
Investments	125,805	27,175	152,980			152,980
Accounts Receivable, Net	1	3	4			4
Interest Receivable	2,458	441	2,899			2,899
Governmental Assets:						
Accounts Receivable, Net	1,981	1,069	3,050	41	6	3,097
Advances and Prepayments	5	4	9	596	3	608
Restricted Cash	14	45	59			59
Property and Equipment, Net	17	30	47	2		49
Total Entity Assets	129,821	28,561	158,382	8,139	9,081	175,602
Non-Entity Assets:						
Governmental Assets:						
Accounts Receivable, Net					265	265
Total Non-Entity Assets					265	265
TOTAL ASSETS	**$129,821**	**$28,561**	**$158,382**	**$8,139**	**$9,346**	**$175,867**
LIABILITIES						
Liabilities Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable	$6	$10	$16			$16
Liabilities for Loan Guarantees					$6	6
Uncollected Revenue due Treasury					265	265
Governmental Liabilities:						
Accounts Payable	1	3	4			4
Suspense Account Deposit Fund					1	1
Accrued Payroll and Benefits	3	8	11	$1		12
Other Governmental Liabilities	33,702	2,724	36,426	8,136		44,562
Total Liabilities Covered by Budgetary Resources	33,712	2,745	36,457	8,137	272	44,866
Liabilities Not Covered by Budgetary Resources:						
Intragovernmental Liabilities:						
Accounts Payable	2	5	7			7
Governmental Liabilities:						
Accrued Leave	6	13	19	1		20
Other Governmental Liabilities				5,609		5,609
Total Liabilities Not Covered by Budgetary Resources	8	18	26	5,610		5,636
TOTAL LIABILITIES	**$33,720**	**$2,763**	**$36,483**	**$13,747**	**$272**	**$50,502**
NET POSITION						
Balances:						
Unexpended Appropriations					$9,074	$9,074
Invested Capital	$17	$30	$47	$2		49
Cumulative Results of Operations	96,092	25,786	121,878			121,878
Future Funding Requirements	(8)	(18)	(26)	(5,610)		(5,636)
TOTAL NET POSITION	**$96,101**	**$25,798**	**$121,899**	**$(5,608)**	**$9,074**	**$125,365**
TOTAL LIABILITIES & NET POSITION	**$129,821**	**$28,561**	**$158,382**	**$8,139**	**$9,346**	**$175,867**

COMBINING STATEMENT OF OPERATIONS AND CHANGES IN NET POSITION BY ACTIVITY
FOR THE PERIOD ENDING SEPTEMBER 30, 1996

(Dollars in Millions)

	Medicare HI	Medicare SMI	Total Medicare	Medicaid	All Others	Combined
REVENUE AND FINANCING SOURCES						
Direct Appropriations Expended				$85,826		$85,826
Employment Tax Revenue	$106,943		$106,943			106,943
SMI Premiums		$18,931	18,931			18,931
Federal Matching Contributions		61,702	61,702			61,702
Revenue From Sales of Goods/Services						
CLIA User Fees					$31	31
To The Public					1	1
Intragovernmental					3	3
Interest & Penalties (Non-Fed)					1	1
Interest (Fed)	10,223	1,568	11,791			11,791
Other Revenue and Financing Sources	6,169	4	6,173		3	6,176
Trust Fund Draws	587	1,405	1,992	104		2,096
Revenue Transferred to Program Management	(705)	(1,391)	(2,096)			(2,096)
Collections for Principal Repayments Transferred To The Federal Financing Bank					(3)	(3)
Total Revenues and Financing Sources	**123,217**	**82,219**	**205,436**	**85,930**	**36**	**291,402**
EXPENSES						
Program or Operating Expenses						
Medicare Benefit Payments *(Includes estimated improper payments of $17.8-$28.6 billion)*	139,189	66,646	205,835			205,835
Medicaid Benefit Payments				91,435		91,435
Administrative Expenses	1,278	1,762	3,040	102	33	3,175
Depreciation and Amortization	2	3	5			5
Bad Debts and Writeoffs	93	28	121			121
Quinquennial Military Service Credit Adjustment	2,366		2,366			2,366
Other Expenses	1	3	4		1	5
Total Expenses	**142,929**	**68,442**	**211,371**	**91,537**	**34**	**302,942**
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	**(19,712)**	**13,777**	**(5,935)**	**(5,607)**	**2**	**(11,540)**
Net Position, Beginning Balance, as Restated	115,691	11,441	127,132	15,900	8,025	151,057
Plus (Minus) Prior Period Adjustment	123	580	703	(12,217)		(11,514)
Net Position, Beginning Balance as Restated	115,814	12,021	127,835	3,683	8,025	139,543
Excess (Shortage) of Revenues and Financing Sources Over Total Expenses	(19,712)	13,777	(5,935)	(5,607)	2	(11,540)
Plus (Minus) Non-Operating Changes	(1)		(1)	(3,684)	1,047	(2,638)
NET POSITION, ENDING BALANCE	**$96,101**	**$25,798**	**$121,899**	**$(5,608)**	**$9,074**	**$125,365**

HOSPITAL INSURANCE TRUST FUND PROJECTIONS

(Dollars in billions)

Calendar Year	Total Income	Total Disbursements	Net Increase in Fund	Fund at End of Year	Ratio of Assets to Expenditures
1996	$124.6	$129.9	-$5.3	$124.9	100
1997	127.4	140.2	-12.8	112.2	89
1998	131.4	151.5	-20.1	92.1	74
1999	135.4	164.1	-28.6	63.4	56
2000	139.7	177.7	-37.9	25.5	36
2001	143.8	192.8	-48.9	-23.4 [1]	13
2002	147.9	208.8	-60.8	-84.3	11
2003	151.8	225.9	-74.1	-158.3	-37
2004	155.4	244.0	-88.6	-246.9	-65
2005	159.2	262.9	-103.7	-350.7	-94
2006	162.3	283.2	-120.9	-471.6	-124

[1] Estimates for 2001 and later are hypothetical, since the HI trust fund would be exhausted in those years.

Reflects intermediate assumptions of the 1997 annual report of the Trustees of the HI trust fund.

SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND PROJECTIONS

(Dollars in billions)

Calendar Year	Total Income	Total Disbursements	Net Increase in Fund	Fund at Year End
1996	$85.6	$70.4	$15.2	$28.3
1997	80.9	76.9	4.0	32.3
1998	85.3	84.8	0.5	32.8
1999	94.0	92.5	0.5	33.3
2000	102.9	102.4	0.5	33.8
2001	112.9	112.3	0.6	34.4
2002	124.3	123.6	0.7	35.1
2003	137.0	136.2	0.8	35.9
2004	151.0	150.2	0.8	36.7
2005	168.5	165.9	2.6	39.3
2006	188.0	183.6	4.4	43.7

Reflects intermediate assumptions of the 1997 annual report of the Trustees of the SMI trust fund.

HCFA PROGRAM MANAGEMENT OUTLAYS
(Dollars in millions)

	FY 1994	FY 1995	FY 1996
Research	$72	$73	$75
Medicare Contractors	1586	1582	1498
State Certification	165	139	146
HCFA Administrative Costs	330	367	337
Reimbursables		3	4
Total Outlays	$2,153	$2,164	$2,060

MEDICARE PAYMENT SAFEGUARDS
(Dollars in millions)

	FY 1994	FY 1995	FY 1996
Investments (Outlays)	$412	$428.3	$439.3
Savings			
Medicare Secondary Payer	2,963	3,446	2,889
Provider Audit	1,117	1,306	1,000
Medical & Utilization Review	1,231	1,841	1,862
Total Savings	$5,311	$6,593	$5,751
Ratio of outlays to savings	1:13	1:15	1:13

FMFIA

Material Weaknesses

Medicare Secondary Payer (MSP) HCFA has actively pursued initiatives to improve the MSP program: legislative proposals, litigation against noncomplying insurers, and data matches with SSA and IRS. Even with these current initiatives, some estimates project that the Medicare program may unnecessarily pay out as much as $400 million annually because fiscal intermediaries and carriers do not always identify primary payers. However, due to improvements in the MSP program, savings were $3 billion in FY 1994, $3.4 billion in FY 1995, and $3 billion in FY 1996. The return on investment (ROI) was impressive in FY 1994, for every dollar spent on administrative costs (including recovery), $35 was saved. Because of litigation, the ROI for FY 1995 and FY 1996 was $29 and $26 respectively, for every dollar spent.

Ongoing initiatives will focus on (1) preventing inappropriate primary payments by Medicare through continued implementation and "user friendly" customization of the beneficiary initial enrollment questionnaire, and (2) implementing data sharing agreements between HCFA and private insurers to prevent duplication of primary payments and to assist in recovery.

STATEMENT OF ACCOUNT FOR HI TRUST FUND INVESTMENTS

U. S. TREASURY SPECIAL ISSUES:

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-7/8% maturing June 30, 1997	$16,940,812,000.00	$16,940,812,000.00	$0.00
7-1/8% maturing June 30, 1997	11,513,390,000.00	8,661,018,000.00	2,852,372,000.00
Total Certificates of Indebtedness	**$28,454,202,000.00**	**$25,601,830,000.00**	**$2,852,372,000.00**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$850,544,000.00	$0.00	$850,544,000.00
13-3/4% due June 30, 1998	262,134,000.00	0.00	262,134,000.00
13-1/4% due June 30, 1997	1,450,129,000.00	0.00	1,450,129,000.00
13-1/4% due June 30, 1996	272,853,000.00	272,853,000.00	0.00
13% due June 30, 1996	1,177,276,000.00	1,177,276,000.00	0.00
10-3/4% due June 30, 1998	588,410,000.00	0.00	588,410,000.00
10-3/8% due June 30, 2000	1,277,566,000.00	0.00	1,277,566,000.00
10-3/8% due June 30, 1999	427,022,000.00	0.00	427,022,000.00
10-3/8% due June 30, 1998	427,022,000.00	0.00	427,022,000.00
9-1/4% due June 30, 2003	4,229,944,000.00	0.00	4,229,944,000.00
9-1/4% due June 30, 2002	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2001	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 2000	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1999	1,034,542,000.00	0.00	1,034,542,000.00
9-1/4% due June 30, 1998	1,034,541,000.00	0.00	1,034,541,000.00
9-1/4% due June 30, 1997	1,034,541,000.00	384,920,000.00	649,621,000.00
9-1/4% due June 30, 1996	1,034,541,000.00	1,034,541,000.00	0.00
8-3/4% due June 30, 2005	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2004	6,415,695,000.00	0.00	6,415,695,000.00
8-3/4% due June 30, 2003	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2002	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2001	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 2000	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1999	2,185,751,000.00	0.00	2,185,751,000.00
8-3/4% due June 30, 1998	2,185,752,000.00	0.00	2,185,752,000.00
8-3/4% due June 30, 1997	2,185,752,000.00	2,185,752,000.00	0.00
8-3/4% due June 30, 1996	2,185,752,000.00	2,185,752,000.00	0.00
8-5/8% due June 30, 2002	3,195,402,000.00	0.00	3,195,402,000.00
8-5/8% due June 30, 2001	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 2000	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1999	686,250,000.00	0.00	686,250,000.00
8-5/8% due June 30, 1998	686,251,000.00	0.00	686,251,000.00
8-5/8% due June 30, 1997	686,251,000.00	686,251,000.00	0.00
8-5/8% due June 30, 1996	686,250,000.00	686,250,000.00	0.00
8-3/8% due June 30, 2001	2,509,152,000.00	0.00	2,509,152,000.00
8-3/8% due June 30, 2000	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1999	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1998	1,231,586,000.00	0.00	1,231,586,000.00
8-3/8% due June 30, 1997	1,059,023,000.00	1,059,023,000.00	0.00
8-3/8% due June 30, 1996	1,059,024,000.00	1,059,024,000.00	0.00

Continued

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
8-1/8% due June 30, 2006	$7,316,968,000.00	$0.00	$7,316,968,000.00
8-1/8% due June 30, 2005	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2004	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2003	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 2002	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2001	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 2000	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1999	901,274,000.00	0.00	901,274,000.00
8-1/8% due June 30, 1998	901,273,000.00	0.00	901,273,000.00
8-1/8% due June 30, 1997	901,273,000.00	901,273,000.00	0.00
8-1/8% due June 30, 1996	901,273,000.00	901,273,000.00	0.00
7-3/8% due June 30, 2007	8,184,929,000.00	0.00	8,184,929,000.00
7-3/8% due June 30, 2006	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2005	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2004	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2003	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 2002	867,960,000.00	0.00	867,960,000.00
7-3/8% due June 30, 2001	867,960,000.00	0.00	867,960,000.00
7-3/8% due June 30, 2000	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1999	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1998	867,961,000.00	0.00	867,961,000.00
7-3/8% due June 30, 1997	867,961,000.00	867,961,000.00	0.00
7-3/8% due June 30, 1996	867,961,000.00	867,961,000.00	0.00
7-1/4% due June 30, 2009	8,773,256,000.00	0.00	8,773,256,000.00
7-1/4% due June 30, 2008	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2007	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 2006	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2005	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2004	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2003	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2002	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2001	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 2000	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1999	225,129,000.00	0.00	225,129,000.00
7-1/4% due June 30, 1998	225,130,000.00	0.00	225,130,000.00
7-1/4% due June 30, 1997	225,130,000.00	225,130,000.00	0.00
7-1/4% due June 30, 1996	225,130,000.00	225,130,000.00	0.00
6-1/4% due June 30, 2008	8,548,126,000.00	0.00	8,548,126,000.00
6-1/4% due June 30, 2007	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 2006	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2005	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2004	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2003	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2002	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2001	363,198,000.00	0.00	363,198,000.00
6-1/4% due June 30, 2000	363,197,000.00	0.00	363,197,000.00

Continued

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-1/4% due June 30, 1999	$363,197,000.00	$0.00	$363,197,000.00
6-1/4% due June 30, 1998	363,197,000.00	0.00	363,197,000.00
6-1/4% due June 30, 1997	363,197,000.00	363,197,000.00	0.00
6-1/4% due June 30, 1996	363,197,000.00	363,197,000.00	0.00
6-1/2% due June 30, 2010	9,037,246,000.00	0.00	9,037,246,000.00
6-1/2% due June 30, 2009	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2008	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2007	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2006	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2005	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2004	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2003	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2002	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2001	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 2000	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 1999	263,990,000.00	0.00	263,990,000.00
6-1/2% due June 30, 1998	263,989,000.00	0.00	263,989,000.00
6-1/2% due June 30, 1997	263,990,000.00	263,990,000.00	0.00
6-1/2% due June 30, 1996	263,990,000.00	263,990,000.00	0.00
7 % due June 30, 2011	3,368,466,000.00	0.00	3,368,466,000.00
7% due June 30, 1997	3,009,629,000.00	3,009,629,000.00	0.00
Total Bonds	**$141,936,787,000.00**	**$18,984,373,000.00**	**$122,952,414,000.00**
Total U. S. Treasury Special Issue	**$170,390,989,000.00**	**$44,586,203,000.00**	**$125,804,786,000.00**

STATEMENT OF ACCOUNT FOR SMI TRUST FUND INVESTMENTS DESCRIPTION OF HOLDINGS AS OF SEPTEMBER 30, 1996

U. S. TREASURY SPECIAL ISSUES

Certificates of Indebtedness:	Amount Issued	Less Amount Retired	Net Amount Outstanding
6-7/8% maturing June 30, 1997	$13,863,302,000.00	$13,863,302,000.00	$0.00
7-1/8% maturing June 30, 1997	7,224,220,000.00	3,274,886,000.00	3,949,334,000.00
Total Certificates of Indebtednes	**$21,087,522,000.00**	**$17,138,188,000.00**	**$3,949,334,000.00**

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
13-3/4% due June 30, 1999	$567,103,000.00	$567,103,000.00	$0.00
13-3/4% due June 30, 1998	110,114,000.00	110,114,000.00	0.00
13-3/4% due June 30, 1997	110,115,000.00	110,115,000.00	0.00
13-1/4% due June 30, 1997	368,928,000.00	368,928,000.00	0.00
10-3/4% due June 30, 1998	456,989,000.00	456,989,000.00	0.00
10-3/4% due June 30, 1997	88,061,000.00	88,061,000.00	0.00
10-3/8% due June 30, 2000	733,187,000.00	733,187,000.00	0.00
10-3/8% due June 30, 1999	166,084,000.00	166,084,000.00	0.00
10-3/8% due June 30, 1998	166,084,000.00	166,084,000.00	0.00
10-3/8% due June 30, 1997	166,083,000.00	166,083,000.00	0.00
8-3/4% due June 30, 2005	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2004	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2003	991,433,000.00	0.00	991,433,000.00
8-3/4% due June 30, 2002	991,433,000.00	199,508,000.00	791,925,000.00
8-3/4% due June 30, 2001	547,163,000.00	547,163,000.00	0.00
8-3/4% due June 30, 2000	258,246,000.00	258,246,000.00	0.00
8-3/4% due June 30, 1999	258,246,000.00	258,246,000.00	0.00
8-3/4% due June 30, 1998	258,247,000.00	258,247,000.00	0.00
8-3/4% due June 30, 1997	258,247,000.00	258,247,000.00	0.00
8-3/8% due June 30, 2001	444,270,000.00	444,270,000.00	0.00
8-1/8% due June 30, 2006	1,218,813,000.00	0.00	1,218,813,000.00
8-1/8% due June 30, 2005	227,380,000.00	0.00	227,380,000.00
8-1/8% due June 30, 2004	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2003	227,381,000.00	0.00	227,381,000.00
8-1/8% due June 30, 2002	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 2001	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 2000	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 1999	227,381,000.00	227,381,000.00	0.00
8-1/8% due June 30, 1998	227,380,000.00	227,380,000.00	0.00
7-3/8% due June 30, 2007	1,293,107,000.00	0.00	1,293,107,000.00
7-3/8% due June 30, 2006	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2005	74,295,000.00	0.00	74,295,000.00
7-3/8% due June 30, 2004	74,294,000.00	0.00	74,294,000.00
7-3/8% due June 30, 2003	$74,294,000.00	$0.00	$74,294,000.00
7-3/8% due June 30, 2002	74,294,000.00	74,294,000.00	0.00

Continued

Bonds:	Amount Issued	Less Amount Retired	Net Amount Outstanding
7-3/8% due June 30, 2001	74,294,000.00	74,294,000.00	0.00
7-3/8% due June 30, 2000	74,294,000.00	74,294,000.00	0.00
7-3/8% due June 30, 1999	74,294,000.00	74,294,000.00	0.00
7-3/8% due June 30, 1998	74,294,000.00	74,294,000.00	0.00
7-1/4% due June 30, 2009	1,570,476,000.00	0.00	1,570,476,000.00
7-1/4% due June 30, 2008	47,113,000.00	0.00	47,113,000.00
7-1/4% due June 30, 2007	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2006	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2005	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2004	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2003	47,112,000.00	0.00	47,112,000.00
7-1/4% due June 30, 2002	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 2001	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 2000	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 1999	47,112,000.00	47,112,000.00	0.00
7-1/4% due June 30, 1998	47,112,000.00	47,112,000.00	0.00
7-% due June 30, 2011	1,659,860,000.00	0.00	1,659,860,000.00
7-% due June 30, 2010	1,659,860,000.00	0.00	1,659,860,000.00
7-% due June 30, 2009	89,384,000.00	0.00	89,384,000.00
7-% due June 30, 2008	89,384,000.00	0.00	89,384,000.00
7-% due June 30, 2007	89,384,000.00	0.00	89,384,000.00
7-% due June 30, 2006	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2005	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2004	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2003	89,385,000.00	0.00	89,385,000.00
7-% due June 30, 2002	867,936,000.00	0.00	867,936,000.00
7-% due June 30, 2001	1,659,861,000.00	0.00	1,659,861,000.00
7-% due June 30, 2000	1,659,861,000.00	0.00	1,659,861,000.00
7-% due June 30, 1999	1,659,861,000.00	0.00	1,659,861,000.00
7-% due June 30, 1998	1,659,861,000.00	12,355,000.00	1,647,506,000.00
7-% due June 30, 1997	1,659,861,000.00	1,659,861,000.00	0.00
6-1/4% due June 30, 2008	1,523,363,000.00	0.00	1,523,363,000.00
6-1/4% due June 30, 2007	230,257,000.00	0.00	230,257,000.00
6-1/4% due June 30, 2006	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2005	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2004	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2003	230,256,000.00	0.00	230,256,000.00
6-1/4% due June 30, 2002	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 2001	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 2000	230,256,000.00	230,256,000.00	0.00
6-1/4% due June 30, 1999	$230,256,000.00	$230,256,000.00	$0.00
6-1/4% due June 30, 1998	230,256,000.00	230,256,000.00	0.00
6-1/2% due June 30, 1996	1,923,411,000.00	1,923,411,000.00	0.00
Total Bonds	**$34,873,210,000.00**	**$11,647,516,000.00**	**$23,225,694,000.00**
Total U. S. Treasury Special Issues	**$55,960,732,000.00**	**$28,785,704,000.00**	**$27,175,028,000.00**

Congressional Reports

Congressional Reports

Report on Peer Review Organizations (PRO)

Over the last several years, HCFA has re-engineered the PRO program to better meet the goal of improving the health status of Medicare beneficiaries. The focus of the PRO program has shifted from a balance between utilization review, DRG validation and quality of care review (including beneficiary complaints) to almost total immersion in quality improvement projects through the Health Care Quality Improvement Program (HCQIP). This shift is in line with the Agency's strategic goal of improving the health status of Medicare beneficiaries by promoting the delivery of high quality, effective and efficient health services.

The HCQIP relies on provider-based quality improvement, a data-driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. PROs conduct a wide variety of quality improvement projects that focus on important clinical and non-clinical topics that have the potential to improve care provided to many Medicare beneficiaries. The scopes of these projects vary in size depending on the study purpose and design. For example, there are "national" projects, such as the Cooperative Cardiovascular Project, focusing on improving care provided to Medicare patients suffering heart attacks, which involve most of the hospitals in the country that treat Medicare patients. Individual PROs also design and structure "local" projects in which they involve work collaboratively with specific providers and managed care plans in their areas. Working together as partners, the PROs and providers/plans utilize Continuous Quality Improvement techniques to measurably improve processes and outcomes of care rather than relying on the prior system of medical record review which sought to identify individual instances of poor quality of care, followed by the sanctioning of poor performers.

Under Federal budget rules, the PRO program is defined as "mandatory" rather than "discretionary" because, like Medicare benefits, PRO costs are financed directly from the trust funds and are not subject to the annual appropriations process. PRO Trust Fund outlays in Fiscal Year (FY) 1996 totaled 190 million dollars which is the same amount that was spent in 1995.

In FY 1996, HCFA administered 53 PRO contracts, one per State, the District of Columbia, the Virgin Islands, and Puerto Rico. Four contracts were competed and awarded in FY 1996. Of the remaining 49 contracts, 48 were noncompetitively renewed and one was extended while a potential conflict of interest was resolved. Each contract is reimbursed through a cost plus fixed fee type contract.

Survey and Certification of Medicare and Medicaid Facilities

The Survey and Certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. HCFA administers agreements with State survey agencies to conduct onsite facility inspections to certify facilities for participation in the Medicare and Medicaid programs. Only certified providers and suppliers are eligible to receive Medicare payments or payments from the Medicaid program that is funded through the Medicaid appropriation. A companion Medicaid State certification program is funded through the Medicaid appropriation. In FY 1996, State surveyors conducted 24,092 facility inspections (including 17,227 in nursing homes) and cited 19,460 facilities for deficiencies. Currently there are more than 57,000 certified facilities.

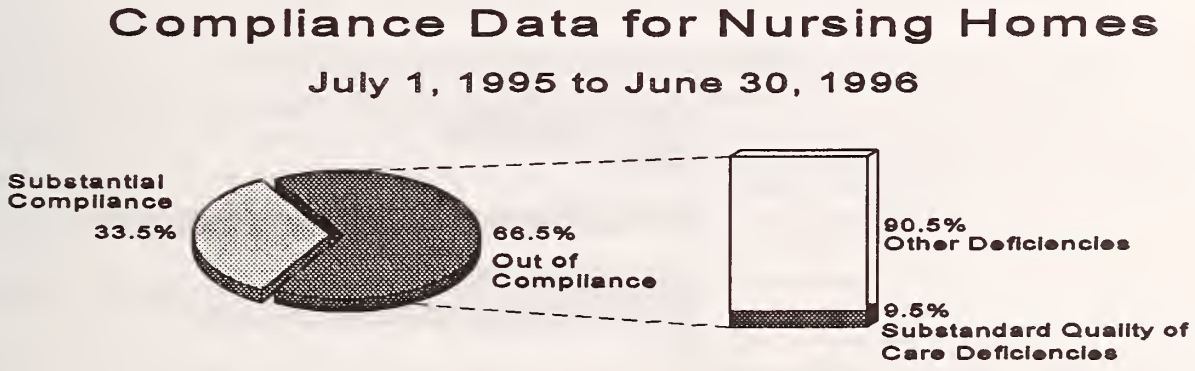
Nursing Home Compliance and Enforcement

Nursing home reforms, mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and implemented in 1990, significantly elevated standards for nursing home care. Among the provisions implemented in 1990 are requirements for higher standards of care for residents, improvements in the quality of residents' daily lives, more beneficiary focused/outcome oriented surveys, and better training of nurse aides. The enforcement aspects of OBRA 87, implemented in 1995, define alternative sanctions for nursing homes that do not meet the revised standards.

In July of 1995, HCFA implemented the enforcement portion of OBRA 87 nursing home reforms. This regulation, which identifies alternative sanctions, was the most controversial portion of the reforms and was implemented only after lengthy consultation with all parties involved in nursing home reform. Prior to the implementation of the 1987 enforcement legislation, the only adverse actions available for HCFA and the States to impose against nursing homes that were out of compliance with the requirements were termination of the provider agreement, denial of participation for prospective providers, and denial of payment for new admissions. The revised enforcement procedures provide HCFA and the States with a variety of remedies to encourage prompt compliance from providers that do not meet the OBRA requirements. These remedies were developed as intermediate or alternative steps that HCFA or the State could implement prior to (and possibly in lieu of) termination of the nursing home from the Medicare and/or Medicaid programs.

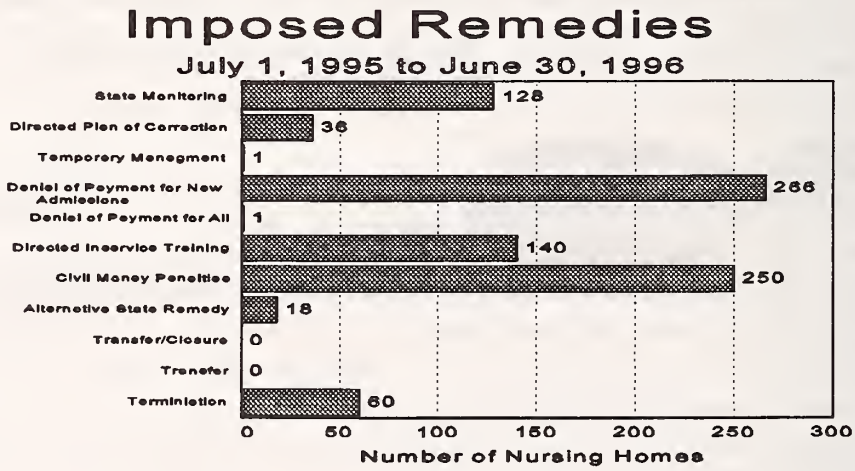
Consistent with OBRA'87, ten alternatives to termination were described in regulation and accompanied by guidelines for their imposition. In addition to termination of the provider agreement, the following remedies were identified:

- State monitoring
- Directed plan of correction
- Temporary management
- Denial of payment for new admissions
- Denial of payment for all admissions
- Directed inservice training
- Civil money penalties
- HCFA approved alternative State remedies
- Transfer of residents with closure of the facility
- Transfer only of Medicaid and Medicare residents



During the first year of implementation of the OBRA '87 enforcement provisions, 17,227 standard surveys of nursing homes were conducted by the State survey agencies. Of these surveys, 66.5 percent found situations which were out of compliance with the requirements. Nationally, 9.5 percent of the surveys cited deficiencies that constitute substandard quality of care, i.e., deficient practice(s) of a higher level acuity under the regulatory requirements covering quality of care, quality of life, and resident behavior and facility practices. The majority of the noncompliant surveys (98.9 percent) allowed the nursing home an opportunity to correct deficiencies prior to the imposition

of remedies if an acceptable Plan of Correction (PoC) was provided by the facility. An acceptable PoC must state how the corrective action will be accomplished for those residents affected by the deficient practice, how the facility will identify other residents having the potential to be affected by the same deficient practice, what measures or systemic changes will be implemented to ensure the deficient practice will not recur, and how the facility will monitor the corrective action and its continued effectiveness. The remaining noncompliant facilities (1.1 percent) were subjected to immediate remedies based upon deficiencies which constituted immediate jeopardy to the health and safety of the residents, and/or were nursing homes considered as poor performing facilities based upon current survey results and previous survey history. Subsequent reevaluation of the noncompliant nursing homes, conducted mostly by revisits to the facilities, determined that 61.9 percent of the resurveys constituted substantial compliance. Consequently, of the total standard surveys conducted, approximately 88 percent were in substantial compliance as of the original survey or the first revisit.



Overall, 899 remedies were imposed in 591 nursing homes (.03 percent). With the exception of transfer and transfer with facility closure, all remedies were utilized. Denial of payment for new admissions and termination continue to be statutorily mandated remedies under the new enforcement procedures when a provider remains out of compliance for three months or six months, respectively. Of the remedies available, 266 denials of payment for new admissions were imposed and 60 providers were terminated during the first year of implementation of the new enforcement procedures for nursing homes.

Validation Surveys of Accredited Laboratories Under the Clinical Laboratory Improvement Amendments of 1988--1995 and 1996

Introduction

This report covers the first evaluation of the performance of the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six approved organizations are the:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatability and Immunogenetics (ASHI)
- College of American Pathologists (College)
- Commission on Office Laboratory Accreditation (COLA)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by statute, we see this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by the Clinical Laboratory Improvement Amendments of 1988 (CLIA), requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accrediting body may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct federal oversight by HCFA. Instead, the laboratory receives an inspection by the accrediting body in the course of maintaining its accreditation, and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e)(2)(D), the Secretary is required to evaluate each approved accrediting body by inspecting a sample of the laboratories they accredit. In addition, section 353(e)(3), requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy this requirement.

Regulations implementing Section 353 are contained in 42CFR Part 493 Laboratory Requirements. Subpart E, contains the requirements for validation inspections conducted by HCFA or its agent, to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 60 days after the accreditation organization's inspection on a representative sample basis or in response to a complaint. The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and

- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, at 42CFR Part 493, Subpart E, section 493.511, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, HCFA can reevaluate whether the accreditation organization continues to meet the criteria for being granted deeming authority. Section 493.511 provides that HCFA also has the discretion to review deeming authority for an accreditation organization if the validation findings indicate such widespread or systematic problems that the organization's requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation activity began in fiscal year 1995 when several approvals were in place. There were comparatively few validation surveys performed during the first year, consequently this review includes validation surveys conducted for both fiscal year 1995 and 1996.

The validation review methodology focuses on the actual implementation of the accreditation organization's process described in its request for deeming authority. The review looks at whether the inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, those areas of the laboratory's operation that are not meeting accreditation standards that were approved by HCFA as being equivalent to, or more stringent than, the CLIA requirements. This equivalency is the basis for granting deeming authority.

For each laboratory in the sample, any findings from the CLIA validation survey that result in deficiencies at the condition level [1] are compared to the accreditation organization's inspection results to identify any differences. If it is reasonable to conclude that one or more of those deficiencies were present in the laboratory's operations at the time of the accreditation organization's inspection, yet the inspection results did not note them, the case is a disparity. When all the cases in the sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys. This process is described in the CLIA regulations.

Results of the Validation Reviews of Each Accreditation Organization

The findings for each organization are summarized below. A number of laboratories are accredited by more than one organization, however, each laboratory holding a CLIA Certificate of Accreditation was counted only once for purposes of the validation review process.

American Association of Blood Banks
American Osteopathic Association
American Society of Histocompatability and Immunogenetics
Rate of disparity: No disparity

Thousands of laboratories nationwide are deemed to meet the CLIA requirements by virtue of their accreditation. For CLIA purposes, only 174 laboratories used their AABB accreditation, only 38 used their AOA accreditation, and only 32 used their ASHI accreditation, so a total of four CLIA validation surveys were performed for these organizations. For this initial evaluation, they were considered sufficient to make the reasonable estimate of performance required by the statute. No condition-level findings were noted in the four validation surveys, and there are no indications that would raise questions about the equivalency of the requirements of AABB, AOA and ASHI accreditation programs.

[1] A "condition-level" requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

College of American Pathologists
Rate of disparity: 3%

For the condition-level requirements, the College's inspection findings were almost always consistent with those of the CLIA validation surveys. The three percent disparity rate is well below the 20 percent threshold that would trigger questions regarding continuing equivalency of requirements. A total of 69 CLIA validation surveys were performed for laboratories accredited by the College. Six laboratories in all were cited with condition-level deficiencies. Three of those six were eliminated from the comparison because they were performed untimely for validation purposes. Of the remaining timely-performed cases, comparable deficiencies were not cited by the College in two of them.

The following is a listing of the laboratory identification number and the location of each laboratory in the cases that had disparate College findings, along with the specific conditions.

CLIA number	Location	Specific Condition
19D0460981	Louisiana	Proficiency Testing (PT) Enrollment
		PT Successful Participation
		General Quality Control (QC)
		Parasitology QC
		Histopathology QC
		Laboratory Director
16D0685413	Iowa	PT Enrollment

Commission On Office Laboratory Accreditation
Rate of disparity: 6%

COLA inspection findings were almost always consistent with those of the CLIA validation findings for the condition-level requirements. For the most part, the COLA surveys examined by the review team reflected a thorough inspection and a comprehensive picture of needed improvements. Of the 122 COLA-accredited laboratories receiving CLIA validation surveys, 19 were cited with condition-level deficiencies. Two other validation surveys found condition-level deficiencies, but were eliminated from the comparison by the review team because they were performed untimely for validation review purposes. Of those 19 cases, the review team found that the COLA inspections did not cite comparable deficiencies in seven of the cases.

Following is a listing of the laboratory identification number and location of each laboratory in the cases that had disparate COLA inspection findings, along with the specific conditions.

CLIA number	Location	Specific Condition(s)
05D0897479	California	Technical Consultant
36D0351805	Ohio	PT Enrollment
36D0333892	Ohio	PT Enrollment
36D0347687	Ohio	PT Enrollment
44D0663681	Tennessee	Laboratory Director
23D0669321	Michigan	Microbiology
23D0378422	Michigan	Quality Assurance
		Technical Consultant

Joint Commission on Accreditation of Healthcare Organizations
Rate of disparity: 5%

For the condition-level requirements, the Joint Commission's inspection findings were almost always consistent with the findings of the CLIA validation surveys. Most of the Joint Commission-accredited laboratories receiving a validation survey were free of condition-level deficiencies. Of the 58 Joint Commission-accredited laboratories receiving CLIA validation surveys, five were cited with condition-level deficiencies. Of those five cases, the review team found that the Joint Commission failed to cite comparable deficiencies in three of the cases.

Following is a listing of the laboratory identification number and location of each laboratory in the cases that had disparate Joint Commission inspection findings, along with the specific conditions.

CLIA number	Location	Specific Condition(s)
03D0669183	Arizona	Technical Consultant--Moderate Complexity
		Technical Supervisor
		General Supervisor
31D0005283	New Jersey	Transfusion Services and Bloodbanking
31D0110766	New Jersey	Cytology
		Transfusion Services and Bloodbanking

Conclusion

The findings of the validation review for 1995 and 1996 indicate that all of the accreditation organizations approved under CLIA performed at a level consistent with continued approval. The rates of disparity for all of the approved accrediting bodies ranged from no disparity to 6 percent--well below the 20 percent threshold that would trigger a deeming authority review. Moreover, the validation review did not reveal widespread or systematic problems of such serious nature that would cause the continuing equivalency of any of the organization's requirements, as a whole, to be questioned.

Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Introduction

Section 1865 of the Social Security Act (the Act) provides that accredited hospitals are deemed to meet the requirements of the Medicare conditions of participation (CoPs), i.e., the requirements of the accreditation organization have been determined to be equal to or more stringent than the Medicare CoPs for hospitals. These hospitals are not subject to routine State Agency surveys to assess compliance with Medicare CoPs. Subsection 1864(c) of the Act, however, authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the JCAHO on a selective sample basis or in response to allegations of significant deficiencies that affect the health and safety of patients. We call this the validation program. The Act further requires, at section 1875, that the Secretary include an evaluation of the JCAHO accreditation process in an annual report to Congress.

The purpose of the validation program is to determine whether the JCAHO's accreditation process provides reasonable assurance that accredited hospitals comply with the statutory requirements at section 1861(e) of the Act for participation in the Medicare program as a hospital. Each year, the Health Care Financing Administration (HCFA) surveys approximately 5 percent of the 4,747 JCAHO accredited hospitals; however, the number actually surveyed may vary depending on available resources.

Sample validation surveys fall into three categories. They are: random sample (hospitals randomly selected for survey within 60 days after the JCAHO survey); 18-month sample (hospitals randomly selected for survey at the midpoint of their 3-year JCAHO accreditation cycle); and conditional sample (hospitals surveyed for selected Medicare requirements based on the JCAHO requirements found not met during their accreditation surveys that caused the JCAHO to render a decision of conditional accreditation). In addition, HCFA performs allegation (complaint) surveys in JCAHO accredited hospitals in response to incoming complaints involving potential threats to the health and safety of hospital patients.

The JCAHO's accreditation survey assesses a hospital's compliance with the JCAHO's standards. After completion of the onsite survey, the JCAHO makes an accreditation decision. The accreditation decisions include: Accreditation; Accreditation with Type I recommendations; Conditional Accreditation; or, in cases where a hospital fails to achieve substantial overall compliance, no accreditation. Accreditation means that the hospital meets all of the JCAHO standards and requirements. Accreditation with Type I recommendations means that the hospital is granted

accreditation with the assurance that the identified recommendations for improvement are implemented. Type I recommendations, which should receive the highest priority in the hospital's plans for improvement, are monitored through a written progress report sent to the JCAHO or through an onsite follow up survey.

Conditional Accreditation is applicable to any hospital that has numerous Type I recommendations which require close monitoring and, without correction, may subject the hospital to a non-accreditation decision. The Conditional Accreditation procedures are designed to prompt these marginal hospitals to expedite efforts to improve performance.

The information presented in the following pages of this report includes the results of the validation and allegation (complaint) surveys and their comparison to JCAHO accreditation survey data. The following summarizes JCAHO's accreditation decisions for calendar years 1995 and 1996.

JCAHO ACCREDITATION DECISIONS

Type of Decision	# of Hospitals 1996	Percentage	# of Hospitals 1996	Percentage
Accreditation	223	13.6	307	18.6
Accreditation with Type I recommendations	1406	85.9	1335	80.6
Conditional accreditation	7	0.4	12	0.7
Total	1636	100	1656	100

Evaluation Summary

For 1995 and 1996, HCFA compared the JCAHO accreditation decision letters and reports with the HCFA regional office decision letters and survey reports completed by the State survey agencies following Medicare surveys. Validation is based on the premise that a JCAHO accreditation survey evaluates a hospital's compliance with requirements at least as stringent as the Medicare CoPs for hospitals. Deficiency data were analyzed for 20 of the 21 Medicare CoPs:[2]

Federal, State and local laws	Quality Assurance	Nursing Services	Radiologic Services
Physical Environment	Food and Dietetic Services	Infection Control	Anesthesia Services
Outpatient Services	Rehabilitation Services	Respiratory Care Services	Governing Body
Medical Staff	Pharmaceutical Services	Laboratory Services	Medical Records
Discharge Planning	Emergency Services	Nuclear Medicine Services	Surgical Services

The following represents an overview of the number of random, 18-month and conditional surveys HCFA performed along with the compliance determinations, i.e., if the results of a validation survey showed noncompliance with one or more of the above listed CoPs, the hospital was determined to be "out of compliance." A hospital may have deficiencies determined to be of lesser severity, i.e., standard level deficiencies, and still be considered in compliance.

Summarized below is a comparison of the compliance pattern between the validation surveys of accredited hospitals and the routine surveys of nonaccredited hospitals, i.e., those surveyed directly by the State survey agencies for compliance with the Medicare CoPs on behalf of HCFA.

[2]The Utilization Review CoP was not surveyed by the State survey agencies because accredited hospitals are subject to binding review by their State Peer Review Organizations (PRO), and the Medicare Utilization Review CoP does not apply when the PRO assumes the review for the hospital. In addition, due to implementation of the Clinical Laboratory Improvement Amendments (CLIA) in 1992, a comparative analysis was performed only for those requirements applicable during 1995 and 1996 that remain under the Medicare CoP of Laboratory Services (one of which is that the hospital laboratory has a certificate that shows it meets the CLIA requirements contained in 42 CFR part 493).

VALIDATION AND NONACCREDITED HOSPITAL SURVEY SUMMARY										
	1995					1996				
	# Out of Compliance	%	# In Compliance	%	Total	# Out of Compliance	%	# In Compliance	%	Total
Random	17	28	44	72	61	10	18	44	82	57
18-month	2	10	19	90	21	10	31	22	69	32
Conditional	2	29	5	71	7	0	0	3	100	3
All Validations	21	24	68	76	89	20	22	72	78	92
Non-accredited	36	17	171	83	207	39	13	259	87	298

Types of Deficiencies

The three general health and safety CoPs found out of compliance most frequently for the 89 validation surveys performed in 1995 and the 92 validation surveys performed in 1996 are shown below. Also included in this summary is information concerning compliance with the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). As part of the Physical Environment (PE) CoP, hospitals must meet the LSC of the NFPA. The LSC is a consensus standard adopted by reference in Federal regulation and provides a reasonable level of safety from fire and other emergencies when followed. Despite LSC not being a CoP, we have reported on it separately in the past because it is a separate process. We are including LSC compliance in this report as a subset of the PE CoP, i.e., we show the number of hospitals whose noncompliance with LSC led to the determination of noncompliance with the PE CoP. A comparison of the pattern of deficiencies between the validation surveys of accredited hospitals and the surveys of nonaccredited hospitals follows.

Most Frequently Cited Conditions of Participation During Validation Surveys of Accredited Hospitals						
	Conditions Not Met - 1995	**F**	**%**	**Conditions Not Met - 1996**	**F**	**%**
1	Physical Environment	10	11	Physical Environment	7	9
	Life Safety Code not met	8		Life Safety Code Not Met	7	
2	Quality Assurance	3	4	Quality Assurance	6	6
3	Medical Staff	4	4	Medical Records for Psychiatric Hospitals	4	4
	Total Hospital Validations	89		Total Hospital Validations	92	

Most Frequently Cited Conditions of Participation During Surveys of Nonaccredited Hospitals						
	Conditions Not Met - 1995	**F**	**%**	**Conditions Not Met - 1996**	**F**	**%**
1	Quality Assurance	18	9	Quality Assurance	22	7
2	Infection Control	14	7	Infection Control	14	4
3	Physical Environment	13	8	Governing Body	10	3
	Life Safety Code Not Met	10				
	Total Surveys of Nonaccredited Hospitals	207		Total Surveys of Nonaccredited Hospitals	298	

F= Frequency of Conditions Not Met

JCAHO Inspection Process for Life Safety Code (LSC)

Beginning January 1, 1995, the JCAHO changed its inspection process for LSC from one of the usual onsite observation and review of a hospital's policies and procedures to one of self-inspection. JCAHO now sends out its Statement of Conditions Compliance Document prior to the upcoming accreditation inspection whereby the facility assesses its own general compliance with the requirements of NFPA 101-1991; LSC, and describes its plan to resolve any identified LSC deficiencies. If, during the onsite accreditation inspection, the JCAHO inspector identifies LSC deficiencies that have not been self-determined and documented by the facility, they are "scored," i.e., they become part of the overall accreditation report as Type I or Type II recommendations. Self-assessed deficiencies are not scored unless the inspector determines that the facility is making little or no progress in correcting that deficiency. Inasmuch as validation surveys are strictly onsite observation and review of hospital policies and procedures for compliance with Medicare requirements and do not include a self-survey process for LSC, any deficiencies noted by surveyors are included on the Federal Form HCFA-2567, Statement of Deficiencies and Plan of Correction. JCAHO accepts the findings of the self-survey for LSC by its accredited hospitals and does not specifically include them in its accreditation report to the facility, except as described above. We have taken that into consideration when making the comparisons between those hospitals inspected by JCAHO and those inspected for validation purposes.

Allegation Surveys

Subsection 1864(c) of the Act, as mentioned before, also authorizes the Secretary to enter into an agreement with any State to survey hospitals accredited by the JCAHO in response to allegations of significant deficiencies that affect the health and safety of patients. The following summarizes the number of allegation (complaint) surveys performed in JCAHO accredited hospitals in 1995 and 1996 and the most frequent CoPs not met.

Allegation Surveys in Accredited Hospitals									
1995					1996				
# Out of Compliance	%	# In Compliance	%	Total	# Out of Compliance	%	# In Compliance	%	Total
43	3	1539	97	1582	35	2	1676	98	1711

Most Frequently Cited Conditions of Participation in Allegation Surveys of Accredited Hospitals						
	Conditions Not Met - 1995	**F**	**%**	**Conditions Not Met - 1996**	**F**	**%**
1	Quality Assurance	24	1.5	Nursing Service	17	1.0
2	Federal, State and Local Laws	16	1.0	Quality Assurance	16	0.9
3	Nursing Service	13	0.8	Federal, State and Local Laws	10	0.6

F=Frequency of Conditions Not Met

Rate of Disparity

As set forth at section 488.8(d)(2)(i) of the Code of Federal Regulations (CFR), following the end of a validation review period HCFA will identify any accreditation programs for which validation survey results indicate a rate of disparity between certification by the accreditation organization and certification by the State agency of 20 percent or more. Accreditation programs for which a 20 percent or more disparity rate is calculated will be subject to a deeming authority review to determine if that organization has indeed adopted and maintained requirements comparable to HCFA's.

Out of the 89 JCAHO validation surveys performed in 1995, 21 showed condition-level noncompliance. When we compared the survey reports of these hospitals with the corresponding accreditation reports, six showed comparable condition-level deficiencies. This equals a disparity rate of 17 percent (below the 20 percent cutoff for further HCFA action).

Out of the 92 JCAHO validation surveys performed in 1996, 20 showed condition-level noncompliance. When we compared the survey reports of these hospitals with the corresponding accreditation reports, eight showed comparable condition-level deficiencies. This equals a disparity rate of 13 percent (below the 20 percent cutoff for further HCFA action).

Changing the Evaluation Methodology

HCFA has embarked on a project to reinvent the way in which we evaluate the total accreditation program of those organizations to whom we have granted deemed status, i.e., accrediting organizations approved by HCFA whereby providers may use their accreditation status from these organizations to meet Medicare requirements in lieu of inspection by the State survey agency. This project includes how we evaluate the onsite survey processes the deemed organizations employ. One

principle guiding the development of a new validation program is that HCFA's evaluation of approved accrediting organizations should be systemic; that is, it should evaluate pre-survey, intra-survey and post-survey activity. The charge is to directly measure the effectiveness of the surveyor at the time he/she performs the survey using the organization's accreditation requirements to determine the functional status of the hospital. HCFA has completed the development of the new program as well as the pilot of the validation reinvention process in hospitals accredited by JCAHO and the American Osteopathic Association. The results of the pilot should be compiled and a summary report completed within FY 97, and we expect to begin implementation of the reinvented evaluation process during FY 98.

Conclusions

Generally, accredited hospitals have few problems meeting the Medicare CoPs. As compared to previous years, validation surveys show that the CoP of Physical Environment continues to be the most frequently cited condition based on noncompliance with LSC requirements. Overall, validation of JCAHO hospitals indicates a downward trend of noncompliance with the Medicare CoPs. The following illustrates that trend.

Validation Survey Noncompliance Summary

	1993	1994	1995	1996
	% Out of Compliance	% Out of Compliance	% Out of Compliance	% Out of Compliance
Random	31	28	28	18
18-month	39	26	10	31
Conditional	29	8	29	0

The JCAHO category of "conditional accreditation" continues to be a great incentive to cause hospitals to take notice and correct their problems in a timely manner. Of the 10 validation surveys performed in 1995 and 1996 in JCAHO conditionally accredited hospitals, eight had made corrections sufficient enough that at the time of the validation survey no condition-level deficiencies were noted. In addition, the results of allegation surveys show very low noncompliance rates, indicating that in most cases, a complaint did not lead to the determination of noncompliance at a level considered to significantly impact the health and safety of hospital patients.

Auditors' Opinion

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date · JUL 17 1997

From June Gibbs Brown
Inspector General

Subject Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 (CIN: A-17-95-00096)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached is our final report entitled *Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996.*

Because of the significance of the following matters and because we were not able to apply other auditing procedures to satisfy ourselves as to the fair presentation of the accounts involved, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the Health Care Financing Administration's (HCFA) Fiscal Year (FY) 1996 financial statements.

- **Medicare Accounts Payable.** The HCFA did not provide adequate support for its accounts payable estimate. We were unable to determine through alternate audit procedures whether the $36.1 billion reported Medicare accounts payable balance was fairly presented.

- **Supplementary Medical Insurance (SMI) Revenue.** The Social Security Administration is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the SMI trust fund each month. Because the SMI revenue has not been audited and because the Office of Inspector General lacks legislative authority to perform this work, we were unable to determine whether the SMI revenue account of $18.9 billion, as well as the Federal match of $61.7 billion, which is material to HCFA's statement of operations, was fairly presented.

- **Medicare/Medicaid Accounts Receivable.** Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity. As a result, we could not determine if the reported $2.68 billion Medicare accounts receivable balance was fairly presented. In addition, we were unable to perform sufficient procedures to satisfy ourselves as to the reasonableness of Medicaid accounts receivable.

- **Cost Report Settlements.** Due to the limited scope of contractors' audits of provider cost reports, we were unable to determine what adjustments, if any, were necessary to the $3 billion in cost settlements from prior years reported in the FY 1996 financial statements.

As discussed in our report on compliance with laws and regulations, we estimate that during FY 1996 net overpayments totaled about $23.2 billion, or about 14 percent of the $168.6 billion in processed Medicare fee-for-service payments reported by HCFA. Because the Medicare program does not currently provide reasonable assurance of detecting and preventing improper Medicare payments, this also constitutes a material internal control weakness, as discussed below. We are recommending that HCFA develop a process for estimating a national payment error rate as part of its corrective actions on this issue.

Our report on internal controls notes four internal control weaknesses that we consider to be material under standards established by the American Institute of Certified Public Accountants and Office of Management and Budget Bulletin 93-06:

① The HCFA does not have a process for estimating a national error rate for improper payments.

② The HCFA does not have an acceptable method for estimating Medicare accounts payable for financial statement reporting purposes.

③ The HCFA does not have an integrated financial reporting system to properly account for Medicare accounts receivable and other financial management and reporting issues.

④ The HCFA central office has deficiencies in electronic data processing controls relating to security access, system application development, and service continuity.

The material weaknesses relating to Medicare accounts payable and Medicare accounts receivable were reported in previous Chief Financial Officers Act audit reports and remain uncorrected.

We have incorporated informal comments to the draft report where appropriate. Officials in your office have concurred with our recommendations and are in the process of taking corrective action. We appreciate the cooperation the HCFA staff has given us in this audit.

We would appreciate your views and information on the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities at (202) 619-1157.

Page 3 - Bruce C. Vladeck

To facilitate identification, please refer to Common Identification Number A-17-95-00096 in all correspondence relating to this report.

Attachment

cc:
Steven A. Pelovitz
Chief of Operations
Health Care Financing Administration

Michelle Snyder
Deputy Chief of Operations
Health Care Financing Administration

Elizabeth Cusick
Director, Office of Financial Management
(and Chief Financial Officer)
Health Care Financing Administration

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REPORT ON THE FINANCIAL STATEMENT AUDIT OF THE HEALTH CARE FINANCING ADMINISTRATION FOR FISCAL YEAR 1996

JUNE GIBBS BROWN
Inspector General

A-17-95-00096
JULY 1997

INDEPENDENT AUDITOR'S REPORT
INSPECTOR GENERAL'S REPORT ON THE HEALTH CARE FINANCING ADMINISTRATION'S FINANCIAL STATEMENTS FOR FISCAL YEAR 1996

To: Bruce C. Vladeck
Administrator
Health Care Financing Administration

We undertook to audit the accompanying combined statement of financial position of the Health Care Financing Administration (HCFA) as of September 30, 1996, and the related combined statement of operations and changes in net position for the fiscal year (FY) ended September 30, 1996 (principal financial statements). These financial statements are the responsibility of HCFA's management and include the accounts of all funds it administers: the Medicare hospital insurance (HI) trust fund, the Medicare supplementary medical insurance (SMI) trust fund, and Medicaid grants.

Except for the following limitations on the scope of our work on the principal financial statements, we did our work in accordance with generally accepted government auditing standards and Office of Management and Budget (OMB) Bulletin 93-06. Because of the significance of the following matters and because we were not able to apply necessary auditing procedures to satisfy ourselves as to the fair presentation of the financial statements taken as a whole, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the principal financial statements:

- ***Medicare Accounts Payable.*** As of September 30, 1996, reported Medicare accounts payable totaled $36.1 billion and comprised 71 percent of total liabilities. These payables represent HCFA's estimate of actual or potential claims for services provided to beneficiaries but not paid at the end of the FY. The HCFA did not provide adequate support for this estimate. Additionally, we were unable to determine, through alternative audit procedures, if the September 30, 1996, Medicare accounts payable balance

was fairly presented. Specifically, we could not find support for $18.3 billion of the accounts payable amount using historical claims data adjusted for costs associated with interim payments to providers and settlements from providers' cost reports. Moreover, using expenditure trends to assess the reasonableness of the payables estimate, we noted that Medicare expenditures increased 16 percent while the accounts payable increased 64 percent. Historically, when compared with expenditures, the payables had erratic and inconsistent changes which HCFA could not explain.

- ***Supplementary Medical Insurance Revenue.*** The Social Security Administration is responsible for withholding premiums from SMI beneficiaries' Social Security checks and for transferring these funds to the Part B trust fund each month. Premiums collected from beneficiaries, which also include collections from other sources, totaled $18.9 billion in FY 1996. These premiums were matched by a $61.7 billion contribution from the Federal Government. The Congress sets the premium rate based on data provided by the HCFA actuary. We did not review the rate setting process, nor has the SMI revenue been audited. Further, the Office of Inspector General (OIG), Department of Health and Human Services (HHS), lacks statutory authority to audit another Federal agency. As such, we were unable to determine whether the SMI revenue account of $18.9 billion, as well as the Federal match of $61.7 billion, which is material to HCFA's statement of operations, was fairly presented.

- ***Medicare/Medicaid Accounts Receivable.*** Reported net Medicare accounts receivable totaling $2.68 billion at September 30, 1996, are amounts providers owe due to overpayments. Medicare contractors did not maintain adequate documentation to support reported accounts receivable activity and to provide adequate audit trails. At several contractor locations, millions could not be reconciled to contractor-reported amounts. As a result, we could not audit the accounts receivable balance because contractors could not support amounts reported to HCFA and because contractors inconsistently applied HCFA accounting policies. In addition, we were unable to perform sufficient procedures to satisfy ourselves on the reasonableness and accuracy of the Medicaid accounts receivable.

Currently, States reported only an estimated $400 million as receivables, and we are concerned that this could be substantially understated.

- ***Cost Report Settlements***. Part A providers are paid interim amounts throughout the year and subsequently file a cost report to reconcile actual costs to the interim payments received. In FY 1996, approximately 37,700 cost reports were due from providers. The value of the Medicare payments to all institutional providers for FY 1996 was about $125 billion. Typically, these payments will not be settled for 2 years. Although HCFA does have a cost report audit process, the provider audit function is limited to specific issue areas or cost report line items and covers only a limited number of providers. Due to the limited scope of the contractors' provider audit function, there is no assurance that amounts eventually paid to providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness. Therefore, we were unable to determine what adjustments, if any, were necessary to the $3 billion in cost settlements from prior years, as well as any subsequent adjustments that may be necessary to the cost reports filed for the FY 1996 financial statements.

We also note that HCFA's financial statements include investment and interest activity which is reported to HCFA by the United States Treasury. Our audit scope was limited to determining the correct recording of the amounts reported by Treasury.

With respect to the FY 1995 statements which are being presented for comparative purposes, we were unable to satisfy ourselves as to Medicare accounts receivable and accounts payable balances and Medicaid accounts receivable and accounts payable balances. Accordingly, we do not express an opinion on the FY 1995 statement of position. The FY 1995 statement of operations and changes in net position was not audited by us, and we do not express an opinion.

The HCFA's Financial Report. The financial information presented in *HCFA's FY 1996 Financial Report,* including the management overview, is supplemental information required by OMB Bulletin 94-01 and is not a required part of the principal financial statements. This information, which includes trust fund

projections, has not been subjected to audit procedures. Accordingly, we express no opinion on it.

Report on Compliance with Laws and Regulations

Compliance with laws and regulations applicable to HCFA is the responsibility of HCFA's management. We performed tests of HCFA's compliance with certain provisions of the following laws and regulations. However, our objective was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion.

- Title XVIII and XIX of the Social Security Act, as amended, and implemented in regulation 42 of the Code of Federal Regulation (CFR);
- Chief Financial Officers (CFO) Act of 1990;
- Government Management Reform Act of 1994;
- Federal Managers' Financial Integrity Act (FMFIA) of 1982;
- Anti Deficiency Act;
- Prompt Payment Act;
- Civil Service Reform Act of 1978, as amended;
- Civil Service Retirement Act of 1930;
- Fair Labor Standards Act;
- Federal Employees Compensation Act;
- Budget Accounting and Procedures Act of 1950;
- Single Audit Act of 1984;
- Federal Employees Group Life Insurance Act of 1980; and
- Federal Employees Retirement System Act of 1986.

Material instances of noncompliance are failures to follow applicable laws and regulations to the extent that the effects of such noncompliance, in the aggregate, cause the financial statements to be misstated. The results of our tests of compliance disclosed a material instance of noncompliance. The estimated net effect of the following material noncompliance issue has been reflected in HCFA's FY 1996 financial statements.

Medicare Fee-for-Service Payments Made Under Title XVIII of the Social Security Act

The Medicare program is inherently vulnerable to incorrect provider billing practices. Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,314 fee-for-service claims processed for payment during FY 1996, we found 1,577 that did not comply with Medicare laws and regulations. By projecting these sample results, we estimate that during FY 1996 net overpayments totaled about $23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments. These improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Specifically, 99 percent of the improper payments in our sample were detected through medical record reviews coordinated by the OIG in conjunction with medical personnel. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. Although HCFA has recognized the need to reduce Medicare overpayments, a system is needed to objectively measure the amount of improper payments so that performance can be measured and corrective action taken promptly.

Audit Objective

The complexity of HCFA's reimbursement systems and policies, the reported instances of fraud and abuse, and the decentralized structure of the Medicare program contributed to the OIG's preliminary assessment of high inherent and control risk in the FY 1996 Medicare benefit payment expenses. As a result, we placed limited reliance on HCFA's internal control structure and expanded our testing to be reasonably sure of detecting material misstatements in the determination of financial statement amounts.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 CFR for services that were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Audit Methodology

Statistical Selection Method. To accomplish our objective, we used a multistage stratified sample design. The first stage consisted of a random selection of 12 contractor quarters during FY 1996. Our sample frame consisted of 236 quarters (59 contractors x 4 quarters). The selection was based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used FY 1995 Medicare fee-for-service benefit payments as the selection weighting factors. For the 12 contractor quarters, 10 contractors were included (2 contractors were included twice). Of the 10, 5 are both fiscal intermediaries (FIs) and carriers, 4 are FIs, and 1 is a carrier. The FIs process payments for hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), rural health clinics, hospices, end stage renal disease facilities, and other institutional type providers. Carriers process payments to physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers.

The second stage consisted of a random sample of 50 beneficiaries from each contractor quarter stratified into 4 strata by total amount of payments for services. The random sample of 600 beneficiaries produced 5,314 claims for review valued at $5.2 million. To ensure the completeness of the claims data, we reconciled Medicare contractor claims data to the HCFA 1522 Monthly Financial Report for the 12 contractor quarters selected. The HCFA used this report to assist in its preparation of the FY 1996 financial statements.

We used a variable appraisal program to estimate the dollar impact of improper payments in the total population. The population represented $168.6 billion in fee-for-service payments.

Audit Procedures. We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. Specifically, we used medical review personnel from HCFA's Medicare contractors and peer review organizations (PROs) to assess the medical records and to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations. Each provider selected in our sample was contacted by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response from our initial letter, followup contacts were made by a second letter and, in most instances, by additional telephone calls. Throughout the medical review, we coordinated OIG and medical review efforts to ensure consistency and accuracy. Concurrent with the medical review, we made additional detailed claims reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Results of Review

Our review indicates that the Medicare program is inherently vulnerable to incorrect provider billing practices. Through detailed medical and audit review of

a statistical selection of 600 beneficiaries nationwide with 5,314 fee-for-service claims processed for payment during FY 1996, we found 1,577 that did not comply with Medicare laws and regulations. The contractors in these cases specifically disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claims adjudication process.

We estimate the point estimate dollar value of improper Medicare benefit payments made during FY 1996 to be $23.2 billion, or about 14 percent of the $168.6 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is $17.8 billion to $28.6 billion, or about 11 percent to 17 percent.

As noted in the following chart, most of the errors in our sample fell into four general categories:

- Documentation, which includes both insufficient and no documentation;
- Lack of medical necessity;
- Incorrect coding; and
- Noncovered/unallowable services.

Estimated Amount of Improper Payments (By Type of Error)

Type of Improper Payment	Estimated Dollars In Improper Payments *(in millions)*	Improper Payments as a Percent of Total
Documentation:	**$10,846**	**46.76%**
Insufficient Documentation	*7,596*	*32.75%*
No Documentation	*3,250*	*14.01%*
Lack of Medical Necessity	**8,529**	**36.78%**
Incorrect Coding	**1,978**	**8.53%**
Noncovered or Unallowable Services	**1,219**	**5.26%**
Other	**620**	**2.67%**
Total	**$23,192**	**100.00%**

A further breakdown of these errors shows that 88 percent of the $23.2 billion occurred within the first 6 provider types below:

Estimated Amount of Improper Payments (Based on Point Estimate)

	Types of Error (in millions)							
Type of Claim	*Lack of Medical Necessity*	*Insufficient Documentation*	*No Documentation*	*Incorrect Coding*	*Non-covered/ Unallowable Service*	*Remaining Errors*	*Total*	*Percentage of Improper Payments*[4]
Inpatient PPS	$3,301	$869	$171	$900		($2)[1]	$5,239	22.59%
Physician	614	1,940	816	1,070	$329	258	5,027	21.68%
Home Health Agency	1,935	1,681	3			31	3,650	15.74%
Outpatient	356	1,381	905	1	85	82	2,810	12.12%
Skilled Nursing Facility	1,365	555	501			3	2,424	10.45%
Laboratory	146	329	844	(14)[2]	30	2	1,337	5.76%
Subtotal	$7,717	$6,755	$3,240	$1,957	$444	$374	20,487	88.34%
Hospice		179			763		942	4.06%
Inpatient Non-PPS	606					18	624	2.69%
End Stage Renal Disease	24	367				226	617	2.66%
Transportation	181	123	4	3	2		313	1.35%
Ambulatory Surgery	1	172	6	18	10	2	209	0.90%
Total	$8,529	$7,596	$3,250	$1,978	$1,219	$620	$23,192[3]	100.00%
Percentage of Improper Payments[5]	36.78%	32.75%	14.01%	8.53%	5.26%	2.67%		

1 *Negative dollars represent claims that were reimbursed using a rate lower than supported.*

2 *Negative dollars represent claims that were reimbursed using a procedure code level lower than supported.*

3 *Range of improper payments at the 95 percent confidence level is $17.781 billion to $28.603 billion. Each dollar estimate is computed consistent with the sampling methodology. The sum of all the dollar estimates equals the overall estimate of $23.192 billion.*

4 *Percentage of the overall estimate of $23.192 billion by the type of claim.*

5 *Percentage of the overall estimate of $23.192 billion by the type of error.*

Each dollar estimate in the previous chart was computed using a method similar to projecting the overall dollar error rate. However, the precision of the dollar estimate by specific type of claim and type of error is not sufficient to use for benchmarking purposes. This would have required an expenditure of audit resources outside the scope of a financial statement audit.

As noted in the chart, 88 percent of our point estimate of improper payments ($20.487 billion) from our sample results occurred in the following provider types:

- **Inpatient Prospective Payment System (PPS)**
- **Physician**
- **Home Health Agency**
- **Outpatient**
- **Skilled Nursing Facility**
- **Clinical Laboratory**

In addition to identifying the errors by provider type, we analyzed the types of errors, as discussed below:

☛ Lack of Documentation

The most pervasive errors for these six provider types were insufficient or no documentation. These 2 error categories accounted for about $10 billion ($6.755 billion for insufficient documentation and $3.240 billion for no documentation), or about 43 percent, of the $23.2 billion in improper payments. As previously indicated, if providers failed to provide documentation or submitted insufficient documentation, the contractors generally requested supporting medical records three times before determining the payment to be improper. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain medical records that

contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care.

Some examples of documentation problems follow:

- **SNF.** A hospital-based SNF was paid $9,365 for a 25-day skilled nursing stay by a 79-year-old patient. The contractor's medical review staff determined that the patient's medical records did not support the provision of skilled nursing care. Medical records documented that the patient received only maintenance-level (nonskilled) nursing home care. Medicare does not reimburse nonskilled services, such as assisting a patient with daily living or meeting personal needs, that could be provided safely by individuals without professional skills or training.

- **Physician.** A physician billed Medicare for 10 hospital visits during a beneficiary's hospital stay and was paid $523. The medical records provided by the physician did not contain support for 8 of the 10 visits. As a result, the medical reviewers concluded that the payments for the other eight visits were not supported, resulting in a $386 overpayment.

- **Clinical Laboratory**. One claim for clinical laboratory services, which included six procedures for automated blood tests, was reimbursed for $64. The medical records did not contain, as required, doctor's orders for the laboratory services billed, nor did they annotate that blood was drawn for testing. As a result, the medical reviewer recommended the claim be denied due to insufficient documentation.

☛ Lack of Medical Necessity

A lack of medical necessity was the second highest error category. For these 6 provider types, a lack of medical necessity accounted for $7.717 billion, or 33 percent, of the $23.2 billion in improper payments. These decisions were made by the contractor or PRO medical review staff using Medicare reimbursement rules and regulations. They followed their normal claims review procedures to determine whether the medical records supported the Medicare claims. Their

findings show that in these cases, based upon the review of the medical records, the services as billed were not medically necessary.

Some examples include:

- **Inpatient.** An acute care hospital received $5,367 to perform certain diagnostic tests that did not require a hospital stay. Based on a medical review, the patient did not have medical conditions justifying the hospital admission. The medical workup, x-rays, bone scan, and consultation could have been carried out in an outpatient setting. Accordingly, the medical reviewer deemed the services medically unnecessary and disallowed the entire payment.

- **SNF.** A SNF received $15,362 for 61 days of care. This payment represented room/board, respiratory therapy services, and other miscellaneous supplies. Based on the medical review, this claim was denied because the medical records did not document a chronic illness or condition necessitating a skilled level of care. The medical reviewer indicated that the patient was stable and that the provider should have known that a skilled service was not necessary. Accordingly, the reviewer disallowed the entire payment.

- **HHA.** An HHA's $11,790 claim for skilled physical therapy, skilled nursing care, and home health aide services was denied because the services were medically unnecessary. The medical reviewer noted that the beneficiary, a resident of a board and care facility, had no functional diagnosis requiring physical therapy or skilled nursing care. The primary diagnosis, according to the medical records, was a "small wound on wrist."

  Another HHA received payment of $1,528 for home health services which were not medically necessary because the services were custodial (care to assist patients with daily living or meeting personal needs) in nature and did not require any skilled care. Therefore, the medical reviewer disallowed the entire claim.

- **Clinical Laboratory.** On August 29, 1996, a laboratory provider billed Medicare for blood work-up without having any diagnosis or specific medical condition for the patient. Further, the ordering physician had not seen the patient since January 18, 1996.

- **Physician.** A physician received a $98 payment for interpretation of an echocardiography performed on December 19, 1995. According to the medical records submitted, a cardiology consultation performed on December 1, 1995, indicated no further followup was necessary. The medical reviewer determined these services were not medically necessary.

☛ Incorrect Coding

Incorrect coding is the third highest error category for these 6 provider types and accounts for $1.957 billion, or about 8.4 percent, of the $23.2 billion in improper payments. Two of the six provider types (inpatient PPS and physician) account for most of the improper payments. Of the remaining four provider types, two types, HHA and SNF, are paid using per diem rates applied to the number of services rendered, not the level of service rendered. Therefore, they do not have coding errors. Incorrect coding for outpatient and laboratory services was immaterial.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the contractor medical review staff determined that the documentation submitted by the provider supported a lower reimbursement amount. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Examples of incorrect coding follow:

- **Inpatient Hospital**. One beneficiary had three separate hospital inpatient admissions during a 3-month period. Medicare paid $8,533 for each admission under one pulmonary diagnosis-related group (DRG). Based on the review of medical records, the medical reviewer concluded that all three claims should have been paid under a less extensive pulmonary DRG that paid at $6,290. This resulted in reducing each claim by $2,243, or a total overpayment of $6,729.

- **Physician**. A physician billed Medicare for a hospital emergency room visit for "treatment of a medical problem of high severity that requires urgent evaluation by the emergency room physician." According to the medical reviewer, the medical records submitted by the provider did not support the level of service billed but rather "treatment for medical problems of moderate severity."

  Another physician billed Medicare for subsequent hospital care requiring "a medical decision of high complexity by the provider" when it should have been for medical care "that is straightforward or of low complexity."

☛ Noncovered/Unallowable Services

Unallowable services for these 6 provider types account for $444 million, or about 1.9 percent, of the $23.2 billion in improper payments. Medicare unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the 1996 Medicare Handbook, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;

- eye or ear examinations to prescribe or to fit glasses or hearing aids;

- most immunizations;
- most prescription drugs;
- blood transfusions furnished on an outpatient basis;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray.

Following are some examples of noncovered or unallowable services identified during our review:

- **Physician Claims.** A physician billed Medicare for an electrocardiogram and various laboratory tests. After reviewing the medical records submitted by the provider, the medical reviewer concluded the billed services should be denied because the services were performed as part of the beneficiary's routine yearly physical examination, which is not a Medicare-covered service.

- **Hospital Outpatient.** A patient was evaluated for foot orthotics, and impressions were taken to make soft arch supports. Arch supports are not covered by Medicare. Although the patient signed a hospital form acknowledging that arch supports were not covered by Medicare, the claim was billed as though it were a Medicare-covered service.

- **SNF Services.** Most of the errors occurred when the SNFs billed Medicare separately for various routine services already included in its flat-rate reimbursement.

Conclusions and Recommendations

The HCFA uses numerous prepayment and postpayment safeguards to prevent or detect improper Medicare benefit payments. For instance, prepayment edits help ensure that billed services are paid accurately and timely, but these controls cannot always detect medically unnecessary, never-rendered, or miscoded services. The HCFA's postpayment medical review is generally effective for identifying abuse and overutilization and for detecting payments for unsubstantiated, medically unnecessary, and noncovered services. However, funding limitations have significantly constrained medical review to the extent that currently only about 3 of every 1,000 providers are subjected to postpayment medical review audit. As our results indicate, a significant opportunity exists for providers to:

- bill for services that are excessive or not medically necessary,
- bill for services that are unsubstantiated per the beneficiary's medical record, and
- improperly code services to obtain higher Medicare payment than the appropriate code would permit.

In view of Medicare's 38 million beneficiaries, 800 million claims processed and paid annually, complex reimbursement rules, decentralized operations, and health care consumers who may not be alert to improper charges, the Medicare program is inherently at high risk for payment errors. Due to limited funding, resources devoted to prepayment and postpayment review have not kept pace with the increase in claims or providers' questionable billing practices. However, even the best developed prepayment and postpayment controls at the contractor level may not be sufficient to prevent or detect material Medicare program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA needs to consider stronger deterrents to reduce improper benefit payments.

Medicare, like other insurers, makes payments based on a standard claim form. Providers are required to retain supporting documentation and make it available upon request. However, a significant portion of the errors we found were

attributable to a lack of or insufficient documentation on the part of providers that claimed payments.

As demonstrated in our review, unnecessary or improper benefit payments continue to plague the Medicare program. Existing risks are sharply increased by the significant growth in Medicare claims and expenditures, the inherent complexities of the Medicare program, and restricted funding for program safeguards to deter abusive providers. Our review has also demonstrated the need for stronger oversight by HCFA to ensure provider compliance with Medicare reimbursement rules and regulations. Recommendations on this issue are detailed on page 21. In addition, among the more important issues HCFA faces in the immediate future is preserving the solvency of the Medicare trust funds.

As part of its strategic plan to safeguard these funds, we recommend that HCFA:

① Develop and implement stronger deterrents to reduce improper Medicare benefit payments.

② Enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare claims.

③ Expand payment safeguard activities and, if necessary, seek additional funding.

④ Direct contractors to expand provider training to further emphasize the need to maintain medical records that contain sufficient documentation and the penalties for not doing so.

⑤ Ensure that contractors recover improper payments identified in our review.

⑥ Direct that contractors follow up with specific providers identified in our sample to address documentation and medical necessity concerns and to determine whether other systemic problems need to be corrected.

⑦ Direct contractors to make followup evaluations of specific procedure codes with high error rates.

REPORT ON INTERNAL CONTROLS

In accordance with OMB Bulletin 93-06, we obtained an understanding of the design of relevant internal control policies and procedures. Except for control policies and procedures relating to performance measurement data, we made sufficient tests of HCFA's internal control structure policies and procedures deemed to have been properly designed and placed in operation to justify a low assessed level of control risk. The purpose of this work was to determine auditing procedures necessary for expressing an opinion on the financial statements, not to provide assurance on the overall internal control structure. Accordingly, we do not express such an opinion.

Because of inherent limitations in any internal control structure, errors or irregularities may occur without detection. Also, projection of any evaluation of the internal control structure to future periods is subject to the risk that procedures may become inadequate if conditions change or if the effectiveness of the design and operation of policies and procedures deteriorates.

The HCFA's management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, management makes estimates and judgments of the expected benefits and costs of internal control structure policies and procedures. The objectives of an internal control structure are to provide management with reasonable, but not absolute, assurance that:

- transactions are properly recorded and accounted for to permit the preparation of reliable financial statements and to maintain accountability over assets;
- funds, property, and other assets are safeguarded against loss from unauthorized use or disposition; and

- transactions, including those related to obligations and costs, are in compliance with laws and regulations that could have a direct and material effect on the principal financial statements and that OMB, HCFA, or we have identified as significant for which compliance can be objectively measured and evaluated.

Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with management's assertions in the financial statements.

Material weaknesses are reportable conditions in which the design or operation of one or more internal control structure elements does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in the financial statements may occur and not be detected within a timely period by employees during the normal course of their duties.

We noted six internal control weaknesses that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants and OMB Bulletin 93-06. We believe that four of these reportable conditions are also material weaknesses as defined above. Two of these material weaknesses (Medicare accounts receivable and accounts payable) were reported in previous CFO audit reports[1] and remain uncorrected. The internal control weaknesses discussed in this report were not identified as material weaknesses by HCFA in the HHS FY 1996 FMFIA report.

[1] *Final reports entitled: "Report on the Health Care Financing Administration's Internal Control Structure and Compliance with Laws and Regulations for the Fiscal Year Ended September 30, 1993" (CIN: A-14-93-03027) dated September 29, 1994; "Inspector General's Report on the Health Care Financing Administration's Combined Financial Statements" (CIN: A-17-94-03032) dated June 30, 1995; "Report on the Health Care Financing Administration's Internal Control Structure Over Medicare Accounts Receivables for the Fiscal Year Ended September 30, 1994 (CIN: A-01-94-00520) dated August 7, 1995; and "Inspector General's Report on the Health Care Financing Administration's Combined Financial Statements" (CIN: A-17-95-00051) dated June 18, 1996.*

MATERIAL WEAKNESSES

Monitoring National Compliance

The HCFA processes an estimated 800 million claims on behalf of its 38 million beneficiaries through a complicated decentralized system involving 59 contractors and multiple shared systems. Because of the inherent risk of improper payments and the 10 percent estimate of fraud, waste, and abuse reported by the U.S. General Accounting Office (GAO), we developed the first national Medicare improper payment error rate. Based on our FY 1996 audit of HCFA's financial statements, we estimate that improper payments approximate $23.2 billion nationwide, or about 14 percent of total Medicare fee-for-service benefit payments. These errors could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. Considering the significance of the error rate, we conclude that HCFA's oversight of the Medicare program does not provide reasonable assurance of detecting and preventing improper Medicare payments. Therefore, this constitutes a material weakness which requires prompt corrective actions. First and foremost, HCFA needs to develop a national error rate for the following reasons:

- to disclose, for financial reporting, Medicare expenditures that do not conform to Medicare reimbursement principles;
- to determine specific corrective actions for controlling improper payments; and
- to develop national performance measurements for error rate reduction and control.

The HCFA's claims processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors discussed on page 8. As previously noted, Medicare,

like other insurers, makes payments based on a standard claim form. Providers are required to retain supporting documentation and make it available upon request.

Because of resource considerations, HCFA placed more emphasis on prepayment reviews, and thus contractors used a variety of software to target medical review efforts on suspect claims. We recognize that HCFA cannot perform "look behind" medical reviews on all claims. However, current controls do not prevent or detect significant Medicare program losses resulting from excessive, unnecessary, or unsubstantiated provider services. Therefore, HCFA must take a more proactive role by focusing on an extensive postpayment analysis of claims to identify the most aberrant procedures and services resulting in improper payments.

We believe that prepayment edits and look-behind medical reviews are the most important tools to detect and prevent improper payments. Currently, such factors as a contractor's budget and workload influence the number of prepayment edits and the extent of look-behind medical reviews. Because of the significance of the national error rate, HCFA needs to take aggressive steps to strengthen controls over monitoring the integrity of claims. Accordingly, HCFA should consider additional prepayment edits and look-behind reviews to detect and prevent the improper payments noted in our review.

In addition to recommendations on pages 17 and 18, we recommend that HCFA:

① Develop a system that estimates improper payments objectively and periodically and disclose the range of such payments in its financial statements.

② Develop a national error rate to focus corrective actions and measure performance in reducing improper payments.

③ Report the lack of a national error rate process as a material internal control weakness in the HHS FY 1997 FMFIA report.

④ Continue to update its systems' capabilities to keep pace with questionable billing practices.

Medicare Accounts Payable

As previously discussed, we were unable to determine the reasonableness of the Medicare accounts payable balance totaling $36.1 billion at September 30, 1996. The first analysis that we made to determine the reasonableness of the payables estimate was to compare FYs 1992-1996 expenditures with accounts payable data. There should be a direct relationship between Medicare expenditures and estimated unpaid claims at yearend.

As noted in the chart below, the account payable estimate showed erratic and inconsistent changes compared with expenditures:

Medicare Accounts Payable and Claim Expenditures

FY	Accounts Payable Percent Change	Claim Expenditures Percent Change
1993	-11%	6.0%
1994	77%	24.0%
1995	-12%	.7%
1996	64%	16.0%

Our next analysis was a comparison of actual claims data for services rendered but not paid at yearend with HCFA's actuarial estimate of accounts payable. The HCFA's acturial estimate for the Medicare accounts payable liability was developed as a byproduct of the long-term trust fund projections, not as a separate analysis for financial reporting. According to HCFA, trust fund projections are based on actual claims, nonclaims payments, and a variety of trends. One of the key ingredients HCFA uses for the payables estimation process is paid claims data from its National Claims History (NCH) file. Although we did not audit the completeness or validity of the NCH file, we obtained monthly NCH reports on current-year payments for services provided in past FYs. This should represent the majority of the yearend liability of unpaid claims.

We compared HCFA's FY 1993-1996 payables estimates with NCH data. As noted below, we found significant differences between these estimates and actual claims data. The HCFA could not explain these differences.

Comparison of Estimates of Accounts Payable Liability

FY	HCFA's Actuarial Estimate (in billions)	Claims History (in billions)	Difference (in billions)
1993	$14.1	$11.2	$2.9
1994	24.9	13.4	11.5
1995	22.0	13.7	8.3
1996	36.1	17.8	18.3

In addition, by contract with an actuary, we reviewed HCFA's FY 1996 Medicare accounts payable estimate. The actuary identified a $4.5 billion computation error in the accounts payable estimate. This error increased the reported Medicare accounts payable 14 percent.

In our opinion, HCFA's method of estimating the Medicare accounts payable is inadequate for accurate accrual-based financial statements and constitutes a material internal control weakness.

Recommendations

We recommend that HCFA:

① Revise its method of estimating Medicare accounts payable to more correctly reflect services provided but not paid at yearend and periodically reconcile the estimate to paid claims data.

② Report the lack of an acceptable method for estimating Medicare accounts payable for financial statement reporting purposes as a material weakness in the HHS FY 1997 FMFIA report.

Need for Improved Financial Management Controls

The OMB Bulletin 94-01 requires that financial statements be the culmination of a systematic accounting process. The HCFA does not have an integrated accounting system that captures Medicare contractor expenditures. Instead, HCFA relies on a complex reporting system and ad hoc reports to accumulate financial data.

At selected Medicare contractors, we noted millions of dollars in unsupported or unrecorded transactions. This problem was caused by the lack of an integrated accounting system linking the HCFA central office to the Medicare contractors. For example, current systems did not contain normal accounting system features, such as a double-entry general ledger system, proper cutoff procedures, and adequate source documentation. As a result, contractors do not have accounting systems that record, classify, and summarize information for the preparation of financial statements. These weaknesses increase the risk of material misstatement in the financial statements. Moreover, HCFA's oversight of financial management controls has not provided reasonable assurance that material errors would be detected in a timely manner.

Details on these matters follow.

☛ Medicare Accounts Receivable

As previously noted, we were unable to satisfy ourselves as to the reasonableness and accuracy of the $2.68 billion in Medicare accounts receivable at September 30, 1996. These are amounts owed Medicare by providers who were overpaid. The OIG previously reported that the internal controls over Medicare accounts receivable processing were not adequate. These problems continue, despite HCFA's efforts to implement financial core requirements and to provide training to ensure that contractors report their financial data in conformance with the CFO Act. Contractors did not have adequate controls or consistently apply

HCFA's accounting policies. Therefore, they did not properly estimate accounts receivable, maintain adequate documentation to support accounts receivable activity, or reconcile reported amounts with subsidiary records.

As discussed below, similar problems were noted in our current review:

- Medicare contractors did not adequately document reported accounts receivable activity or provide adequate audit trails. At one contractor location, approximately $7 million could not be reconciled to reported amounts.

- Some Medicare Part A providers are paid on an interim basis using prior claims activity and related costs (referred to as the periodic interim payment (PIP) method of reimbursement). We found that some contractors used inconsistent accounting procedures to calculate receivables and payables resulting from the PIP reimbursement process. For instance, one contractor incorrectly included $700 million as a receivable when in fact all but $32 million was a payable. Also, four contractors did not record either PIP receivables or payables. One additional contractor included a $25 million PIP payable rather than an $80 million PIP receivable.

- Medicare contractors did not always reconcile the amounts reported on HCFA's Provider Overpayment Report (POR) with the quarterly 750/751 Report. For example, for the same reporting period, a contractor reported accounts receivable of (1) $121.4 million on its HCFA 750, (2) $150 million on its POR, and (3) $112.1 million on its "STOP" report. This contractor was unable to reconcile these variances and determine the true accounts receivable.

- Some Medicare contractors did not maintain an audit trail to ensure that cash collected from overpayments was properly recorded in the individual accounts receivable records. In addition, the receivables sometimes were not adjusted until months after the cash was collected.

As a result of these accounts receivable control weaknesses, HCFA may not be collecting millions of dollars in overpayments from providers. These problems have been addressed in HCFA's corrective action plan for FY 1997 and future years.

☛ Controls Over Cash

We reviewed the contractors' cash procedures to determine whether safeguards were adequate, records were in place, and duties were properly segregated. These controls typically are designed to protect assets against theft, loss, misuse, or unauthorized alteration and to reduce the opportunities for perpetrating and concealing errors or irregularities. Based on our internal control work, we identified the following weaknesses:

- The separation of duties was inadequate. In this regard, the same individual was responsible for receiving and endorsing checks, preparing and recording deposits, and performing bank reconciliations (two contractors).
- The amount reported as outstanding checks on the HCFA 1522 could not be supported by documentation (five contractors).
- General ledgers or subsidiary ledgers supporting cash balances were not maintained (seven contractors).
- Supervisory review of bank reconciliations was not performed (three contractors).
- Check signature lists contained unauthorized contractor personnel (two contractors).
- Contractor time account balances totaling about $59 million initially were not included in HCFA's accounting records.

☛ Financial Reporting and Reconciliations

The reconciliation of "total funds expended" on the HCFA 1522, Monthly Contractor Financial Report, is an important control which ensures that all amounts reported to HCFA by Medicare contractors are accurate, supported, complete, and properly classified. At the Medicare contractor level, "total funds expended" is the sum of all checks drawn and electronic fund transfer payments issued during the calendar month less voided checks and overpayment recoveries. This amount is then further classified by component into the following categories: benefit payments, PIP, accelerated payments, net suspense payments, audit reimbursement adjustments, and interest income and expenses. The HCFA uses the information from this report in preparing its financial statements.

Our analysis of the HCFA 1522 report at the 10 selected Medicare contractors identified the following internal control weaknesses:

- Paid claim activity and "total funds expended" were not formally reconciled. For example, it took several months for the contractors to produce payment tapes that summarized individual claim transactions, to identify adjusting entries, and to establish proper cutoff periods that reconciled with the monthly HCFA 1522.

- The contractors had no internal written policies or procedures for preparing the HCFA 1522.

- In many cases, readily available general ledgers and appropriate subsidiary records were not maintained to support all components of "total funds expended" on the HCFA 1522. For example, to prepare the monthly HCFA 1522 reports, contractors had to obtain data from various sources, such as the computerized claims processing system, bank statements, manually prepared documents and ledgers, and estimates. This data was then manually combined by contractors' accountants into the HCFA reporting formats. However, the source documents were not always maintained or available.

- Some contractors did not subject the HCFA 1522 to independent verification. One contractor had an incorrect allocation of PIP payments between the HI and SMI trust funds, resulting in a $360 million classification error.

Although we noted similar weaknesses in our prior internal control reports issued to HCFA, contractors have not effectively implemented the controls necessary to ensure adequate financial reporting.

Recommendations

To correct the conditions addressed above, we recommend that HCFA:

① Review and monitor the accounts receivable internal control structure to provide reasonable assurance that reported amounts are valid and documented. For example, the HCFA regional offices and/or outside independent audit firms could assess the adequacy of controls.

② Establish an integrated financial management system to promote consistency and reliability in recording and reporting accounts receivable information.

③ Ensure that all contractors establish a general ledger system that incorporates double-entry bookkeeping.

④ Ensure that all contractors develop control procedures to provide independent checks to ensure the validity, accuracy, and completeness of the amounts reported to HCFA, including a reconciliation with the contractors' supporting documentation.

⑤ Ensure that contractors receive ongoing training on the HCFA 750/751 report.

⑥ Include the issues relating to financial management discussed in this report in the HHS FY 1997 FMFIA report.

MATERIAL WEAKNESS/REPORTABLE CONDITION

Medicare Electronic Data Processing Controls

We considered several electronic data processing (EDP) control weaknesses at the HCFA central office, selected Medicare contractor locations, Common Working File (CWF) host sites, the CWF maintainer, and shared system maintainers to be reportable conditions. We considered the control weaknesses at the HCFA central office to be material.

Background

To administer the FY 1996 Medicare program and to process and account for $204 billion in Medicare expenditures, HCFA relied on extensive data processing operations at both HCFA and fiscal contractors that process Medicare claims. The HCFA central office computer center primarily maintains administrative data, such as Medicare enrollment, eligibility, and paid claims data, but it also processes all payments for managed care.

Medicare contractors use one of several "shared" systems to process and pay fee-for-service claims. As part of the claims processing, these systems interface with the CWF to obtain authorization to pay claims. The CWF uses nine distributed data bases to coordinate Medicare Part A and Part B benefits and to approve claims for payment. These data bases are maintained by contractors referred to as CWF hosts. In addition, the shared systems and CWF are designed and maintained by a separate contractor referred to as the system maintainer.

Controls associated with the general data processing environment are critical to ensuring the reliability, confidentiality, and availability of HCFA data. Such controls, which are referred to as EDP general controls, generally relate to the entity-wide security program, access controls, application development and change controls, segregation of duties, operating system software, and service continuity. The EDP general controls affect the integrity of all applications operating within a single data processing facility.

Our review of EDP internal controls was limited to general and application controls and did not include management or operations controls.

The HCFA Central Office

The EDP general controls at the HCFA central office are ineffective. As noted in the chart below, each of the six EDP general control areas had weaknesses:

EDP Assessment of HCFA Central Office and Selected Medicare Locations
General Control Review Findings
(Summary)

General Control Audit Areas	Findings at HCFA Central Office	Number of Medicare Contractors with Findings (6 Reviewed)	Number of CWF Host Sites with Findings (4 Reviewed)
Entity-Wide Security Program	Yes	4	1
Access Control	Yes	5	3
Application Software Development and Change Control	Yes	5	4
Segregation of Duties	Yes	2	0
System Software	Yes	3	2
Service Continuity	Yes	1	1
Overall Assessment			
Effective	--	4	1
Ineffective	Yes	2	3

Weaknesses in EDP general controls were also demonstrated through a system penetration test in which we obtained access privileges to read or modify sensitive

Medicare enrollment, beneficiary, provider, and payment information. The specific vulnerability identified was immediately corrected.

In addition, HCFA's entity-wide security program was ineffective. This program should provide a framework for managing risk, developing security policies, assigning responsibility, and monitoring the adequacy of computer-related controls. The HCFA had not made risk analyses or developed security plans for its computer center, telecommunications, networks, or significant applications. As a result, HCFA management had no assurance that cost-effective controls were implemented to manage risks associated with the systems. In addition, HCFA's security structure was not adequate to ensure that security program objectives were achieved.

Access controls did not adequately protect data from unauthorized modifications or destruction. Application developers were allowed update access to production data for many sensitive applications in a manner that would bypass audit trail controls. In addition, access control software was configured so that it did not adequately protect HCFA's 400,000 tapes. Furthermore, the use of sensitive utilities that could bypass access controls was not monitored. All of these weaknesses could allow users to modify production data without detection.

We also identified serious application development and change control weaknesses. The centralized production control group controlled only about 15 percent of the production batch programs. In addition, HCFA did not use its library management software to perform version control over application source codes or to ensure that the executable program code was created from the appropriate source code. Because of these weaknesses, HCFA risks implementing unauthorized programs. This could result in improper processing of certain Medicare payments or eligibility information and could allow malicious programming changes that could interrupt data processing or destroy data files and programs.

In addition, electronic data processing functions were not adequately separated to prevent one individual from controlling key aspects of computer-related operations. For example, one systems programmer also served as a backup

security administrator. This assignment of duties could permit one person to make unauthorized and undetected changes to operating system software products.

Controls over operating system software integrity and changes were also ineffective. The operating system software was not adequately restricted. The HCFA had allowed 67 contractors and 17 systems personnel update access to the operating system software. This excessive access increased the risk of accidental corruption of the operating system, and this risk was exacerbated by HCFA's inadequate control over system software changes. Of the 53 system software changes that we tested, 27 were implemented without proper approval.

Finally, service continuity controls had serious weaknesses. These controls should ensure that critical operations continue without interruption or are promptly resumed and that critical and sensitive data are protected when unexpected events occur. The HCFA had not updated its critical application list in the contingency planning document since 1992. Because several applications had been developed, modified, and combined since then, HCFA's contingency plan could not ensure that critical applications would be promptly restored in the event of a disaster.

Medicare Contractors

We assessed the EDP general controls at six Medicare contractors and four CWF host sites. As shown in the chart on page 30, four of the Medicare contractors and one of the CWF host sites had effective general controls, but significant weaknesses were found at these locations in many of the six areas of general controls.

Furthermore, two Medicare contractors and three CWF host sites had ineffective general controls. These weaknesses could allow sensitive medical history information, personal beneficiary data, and claim information to be inappropriately disclosed or altered.

At selected Medicare contractors, we found instances where provider termination information was not communicated in a timely manner, passwords were easily

determinable, some systems programmers had unnecessary access to alter sensitive data bases, and some computer operators had powerful security privileges which gave them access to the security data base.

In addition, at some of the CWF host sites, risk assessments were not always performed, policies on removing sensitive information from data storage devices before disposal were missing, password change intervals were too long, password selection criteria were inadequate, and privileged access authority was granted to an excessive number of users.

Furthermore, as evidenced by the varied findings among the Medicare contractors, HCFA does not have a consistent set of policies to oversee and review the effectiveness of general controls at its contractor locations. As such, HCFA has not adequately monitored these contractors in prior years. However, in response to prior recommendations, in FY 1996 HCFA began a program to contract EDP control assessments at selected contractors.

Conclusion and Recommendations

The Medicare program relies on automated systems to administer virtually all aspects of the program. Accordingly, based on the significance of these weaknesses, the need for improvements in EDP controls at the central office system is considered to be a material weakness, and the ineffective controls at the Medicare and CWF host contractors are considered to be reportable conditions for purposes of this internal control report.

For the central office EDP controls, we recommend that HCFA implement cost effective improvements to ensure that:

① An entity-wide security structure is implemented to achieve security program objectives. Specifically, ensure that easily guessed passwords (e.g., system passwords used by installers and passwords related to functions being performed) are not used, enforce periodic password changes, and record and track access to sensitive data with a hard copy report to the responsible system manager.

② Access controls are adequate to protect data and other resources from unauthorized modification or destruction.

③ Application development and program change control procedures protect against unauthorized changes.

④ Assigned responsibilities adequately segregate computer-related duties.

⑤ Controls over system software integrity and changes properly restrict access to authorized personnel and protect against unauthorized changes.

⑥ Service continuity plans are current and periodically tested.

⑦ The process of evaluating EDP controls at the contractor level continues. All contractors should be periodically assessed, and all findings and recommendations should be tracked through final implementation.

Additionally, HCFA should report the material weaknesses associated with the HCFA central office in the HHS FY 1997 FMFIA report.

REPORTABLE CONDITION

Medicaid Accounts Receivable and Accounts Payable

For the FY 1996 financial statements, HCFA has recorded a net Medicaid accounts payable that includes an amount for accounts receivable. In previous years, HCFA did not record an amount for accounts payable or receivable because no process was in place to collect this information from the States. However, for the FY 1996 financial statements, HCFA did attempt to collect the Federal share of accounts payable and receivable information recorded in the States' financial statements. The HCFA received enough information on accounts payable to reasonably estimate an amount. The information that HCFA received from the States for receivables was very limited and, in some cases, nonexistent. Therefore, we were unable to perform sufficient procedures to satisfy ourselves as to the

reasonableness and accuracy of the Medicaid accounts receivable, which comprise part of this liability.

Recommendations

We recommend that HCFA:

① Continue to survey States annually for Medicaid accounts receivable and payable data and provide clear and complete instructions.

② Carefully monitor survey responses and implement procedures to address problems.

③ Develop trend data on accounts receivable and payable by State to improve and further refine the estimation model.

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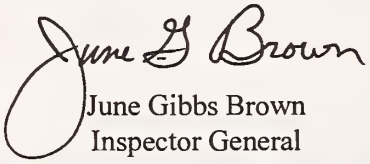
This audit was performed in close cooperation with GAO due to HCFA's significance in the consolidated financial statements of the Federal Government, which GAO has the responsibility to audit. The GAO participated extensively in various segments of the audit and provided significant contributions.

This report, which incorporates HCFA's informal comments where appropriate, is intended for the information of HCFA, the Secretary, and OMB. However, this report is a matter of public record, and its distribution is not limited.



June Gibbs Brown
Inspector General
Department of Health and Human Services

July 17, 1997
CIN: A-17-95-00096

Glossary

GLOSSARY

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: A general term that refers to Medicare and Medicaid administrative costs, as well as HCFA administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-HCFA administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. HCFA administrative costs are the costs of operating HCFA (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an "enrollee").

Benefit Payments: Funds outlayed or expenses incurred for services delivered to beneficiaries.

Carrier: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay physician and supplier claims.

Cost-Based Health Maintenance Organization (HMO/Competitive Medical Plan, CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Demonstrations: Projects and contracts that HCFA has signed with various health care organizations. These contracts allow HCFA to test various or specific attributes such as payment methodologies, preventive care, social care, etc., and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Entity Assets: assets which the reporting entity has authority to use in its operations (i.e., management has the authority to decide how funds are used, or management is legally obligated to use funds to meet entity obligations).

Expenditure: the issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. When used in the discussion of the Medicaid program, expenditures refer to funds spent as reported by the States. The same as Outlay.

Expense: Funds actually spent or *incurred* providing goods, rendering services, or carrying out other mission related activities during a period. Expenses are computed using accrual accounting techniques which recognize costs when incurred and revenues when earned and include the effect of accounts receivables and accounts payable on determining annual income.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not earmarked for a particular use.

FICA (Federal Insurance Contribution Act) Payroll Tax: Medicare's share of FICA is used to fund the HI Trust Fund. In FY 1995, employers and employees each contributed 1.45 percent of taxable wages, with no limitations, to the HI Trust Fund.

FMAP (Federal Medical Assistance Percentage): The portion of the Medicaid program which is paid by the Federal government.

FMFIA (Federal Managers' Financial Integrity Act): A program to identify management inefficiencies and areas vulnerable to fraud and abuse and to correct such weaknesses with improved internal controls.

Governmental Assets, Liabilities: assets or liabilities that arise from transactions between a federal

entity and a nonfederal entity.

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

High Risk Area: A potential flaw in management controls requiring management attention and possible corrective action.

Hospital Insurance (HI): See "Part A."

Intermediary: A private business, typically an insurance company, which contracts with HCFA to receive, review, and pay hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment.

Intragovernmental Assets, Liabilities: assets or liabilities that arise from transactions among federal entities.

Mandatory Spending: Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Material Weakness: A serious flaw in management controls requiring high-priority corrective action.

Medicare Contractor: A collective term for carriers and intermediaries.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

MR/UR (Medical Review/Utilization Review): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MSP (Medicare Secondary Payer): A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Non-Entity Assets: assets that are held by an entity but are not available to the entity. These are also amounts that, when collected, cannot be spent by the reporting entity.

Obligation: Budgeted funds committed to be spent.

Outlay: The issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided or the expense was incurred. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the States for Medicaid benefits.

Part A: Medicare Hospital Insurance, also referred to as "HI."

Part B: Medicare Supplementary Medical Insurance, also referred to as "SMI."

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

PRO (Peer Review Organization): Medicare Contractors which monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Productivity Investments: Spending aimed at increasing contractor operational efficiency and productivity through improved work methods, application of technology, etc.

Program Management: HCFA's operational account. Program Management supplies the agency with the resources to administer Medicare, the Federal portion of Medicaid, and other Agency responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization providing medical services.

Recipient: An individual covered by the Medicaid program, however, now referred to as a beneficiary.

Risk-Based Health Maintenance Organization (HMO)/ Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

SECA (Self Employment Contribution Act) Payroll Tax: Medicare's share of SECA is used to fund the HI Trust Fund. In fiscal year 1996, self-employed individuals contributed 2.9 percent of taxable annual income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Supplementary Medical Insurance (SMI): See "Part B."

Tax and Donations: State programs under which funds collected by the State through certain health care related taxes and provider-related donations were used to effectively increase the amount of Federal Medicaid reimbursement without a comparable increase in State Medicaid funding or provider reimbursement levels.

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